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UNIVERSITY OF ALBERTA

THERAPISTS' EXPERIENCES OF COUNSELLING SUICIDAL CLIENTS

BY

JOAN LOUISE MACKAY ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment of the requirements for the degree of MASTER OF EDUCATION

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1995

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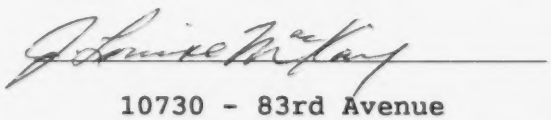

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled THERAPISTS' EXPERIENCES OF COUNSELLING SUICIDAL CLIENTS submitted by JOAN LOUISE MACKAY in partial fulfilment of the requirements for the degree of MASTER OF EDUCATION in COUNSELLING PSYCHOLOGY.

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Abstract

By means of a phenomenological methodology, this study explored therapists' experiences of counselling suicidal clients. Through minimally structured interviews (60 to 90 minutes in length), six therapists, three females and three males, individually described their experiences of counselling suicidal clients. The therapists were chartered psychologists ranging from 40 to 60 years of age, and their years of experience counselling clients ranged from eight to over 30 years. As a result of the data analysis, the following four major themes were developed: 1. Therapeutic Ingredients For Counselling Suicidal Clients, 2. Feelings That Arise When Working With Suicidal Clients, 3. Therapists' Self-Care, and 4. Professional Growth. Subsequently, these themes were validated by the six therapists. The implications of these findings for future research and for therapists counselling suicidal clients are also considered.

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Chapter One

Introduction

Suicide effects the lives of millions of Canadians each year, as many individuals struggle with suicidal ideations, others attempt suicide, and some complete suicide. This is evident as suicide is the fifth leading cause of death in Canada (National Task Force on Suicide in Canada, 1994). Families, friends, and mental health professionals are left trying to piece together the parts of the puzzle that might explain why their loved one, friend, or client chose suicide. Indeed, as the survivors try desperately to understand the act of suicide, in the victims' minds this act may be their only choice. Thus, the survivors are left to cope with their feelings of guilt and responsibility.

In particular, suicide survivors such as mental health professionals are unique in that they not only have to cope with their feelings concerning clients who have completed suicide, but they also must continually deal with clients who are at suicidal risk. The frequency of treating suicidal clients is apparent as suicide is reported to be the most frequently encountered emergency situation by mental health professionals (Schein, 1976, as cited by Bongar, 1991). Not surprisingly, Deutsch (1984) discovered that for therapists, the disclosure of suicidal ideations was the most stressful of all client behaviors, and that

such disclosure would occur about twice a week for the average therapist.

Limited research has been completed in the area of mental health professionals' experiences of working with suicidal clients. Therefore, little is known concerning how mental health professionals cope with the stressfulness of working with attempted and completed suicides. However, regarding the frequency and impact of client suicide on psychologists in the United States, Chemtob, Hamada, Bauer, Torigoe, & Kinney (1988b) reported that 22% of psychologists can expect a client to commit suicide while in treatment; whereas, 39% of psychologists who had previously lost one client to suicide could expect a subsequent suicide. Regarding psychiatrists, Chemtob, Hamada, Bauer, Kinney, & Torigoe (1988a) reported that 50% of them can expect to have a client commit suicide while in treatment. Subsequently, 55% of the psychiatrists who had previously lost a client to suicide could expect a subsequent one. Both of these studies reported that client suicide had a significant impact on the professional and personal lives of both psychologists and psychiatrists, as they indicated feelings of anger and guilt.

In addition to the impact on psychologists and psychiatrists, this is also an all too common occurrence with clinicians in training. Kleepsies, Smith, & Becker (1990) studied clinical psychology master's students during

their training and one in six of these students indicated that they had experienced a client commit suicide. Such suicides had impacted the students in training both professionally and personally, as these students experienced higher stress levels than reported by professional clinicians who had experienced a client suicide.

Similar findings were reported by Schnur & Levin (1985) as they studied the reactions of psychiatric residents when patients they were treating or evaluated suicided. In Schnur & Levin's (1985) study, the psychiatric residents indicated feelings of shock, anger, guilt, sadness, and helplessness when learning of their patient's suicide. As well, the psychiatric residents reported increased fear when working with subsequent patients at suicidal risk.

It is evident that psychologists, psychiatrists, clinicians in training, and psychiatric residents will frequently treat suicidal clients. During this process of treatment, all too many clients will complete suicide. Due to the number of clients who are committing suicide while in treatment and the personal and professional impact on the mental health professionals (Chemtob et al., 1988a, 1988b; Kleepsies et al., 1990; Schnur & Levin, 1985), the study of therapists' experiences of counselling suicidal clients is of clinical significance.

Despite the importance of studying therapists' experiences of counselling suicidal clients, the majority of

the suicide research that has been conducted is in the areas of predicting who is at risk of committing suicide and preventing those at risk from completing suicide (Bongar, 1991, 1992). Few studies (Gurrister & Kane, 1978; Pope & Tabachnick, 1993; Hendin, 1981; Modestin, 1987) have been completed in the area of therapists' experiences of counselling suicidal clients.

Based on the issues of prevalence of completed suicides while in treatment (Chemtob et al., 1988a, 1988b; Kleepsies et al., 1990), stressfulness of treating suicidal clients (Deutsch, 1984; Schnur & Levin, 1985), and the limited research in this area, the need for an investigation into therapists' experiences of counselling suicidal clients is essential for understanding the treatment process. By understanding therapists' experiences of counselling suicidal clients, appropriate changes could occur in the treatment process, not only for the client, but also for the therapist, such as adequate professional and personal support. Such changes may improve the outcome of treatment, thus decreasing the number of suicides.

Since relatively little is known about the therapeutic experience from a therapist's perspective, it seems appropriate to investigate this concern through a qualitative approach, specifically a phenomenological research methodology. A phenomenological approach was utilized as it provided the best means of exploring the

meaning of the therapists' experiences of working with suicidal clients by allowing the therapists to describe the phenomenon from within their inner experiences (Wertz, 1984). Through minimally structured interviews, six therapists were asked individually to describe their experiences of counselling suicidal clients.

Based on the therapists' descriptions of their experiences, this present research study provides an understanding of the phenomenon of therapists' experiences of counselling suicidal clients. In Chapter Two, the relevant literature on the treatment of suicide, the impact of treatment on the clinician, and the status of current graduate training programs in addressing the issue of treating suicidal clients are discussed. In Chapter Three, the rationale for a qualitative, phenomenological research methodology is presented. In addition, the data collection process involved in phenomenological methodology is described. As a result of the data analysis, in Chapter Four, the common themes which emerged as essential structures or markers of the therapists' experiences of counselling suicidal clients are reported. These themes are exemplified and clarified by using quotations from the six therapists' descriptions of their experiences of counselling suicidal clients. Finally, in Chapter Five, the common themes which surfaced through the process of data analysis are discussed in relation to the current research which is

presented in Chapter Two. To conclude, various implications of the findings for counselling and research are described.

Chapter Two

Literature Review

Incidence of Suicidal Behaviours

Suicide, both attempted and completed, represents a serious health concern in Canada today. In 1992, approximately 1.9% of all deaths in Canada were due to suicide. Annually, since 1978 approximately 3 500 Canadians have committed suicide with four times as many males then females completing suicide. In addition, for many years, suicide has ranked among the top five to ten causes of death in North America and most countries in Europe. Specifically, in Canada, suicide is the fifth leading cause of death (National Task Force on Suicide in Canada, 1994).

Indeed, these figures of committed suicide are disturbing as they only represent a small number of the people who attempt suicide. Also, these figures are distressing as we realize that suicide may be statistically under-reported, and that suicidal rates are continuing to increase in most of the industrialized countries (Maris, 1988 as cited by Bongar, 1991).

Suicide Terminology

Due to the rise of suicidal rates, there is a need for the various types of suicidal behaviors to be clearly defined (Hughes & Neimeyer, 1990). Regarding this, there is

a continuing debate in the realm of suicidology concerning how to characterize and classify suicidal behaviors. For instance, suicidal behaviors may refer to various types of suicidal activities, such as suicidal ideations, attempted suicide with or without suicidal intent, and completed suicide (Linehan, 1986).

Regarding efforts towards defining and classifying suicidal behaviors, the task force of the National Institute of Mental Health (NIMH) Center for Studies of Suicide Prevention developed a tripartite classification consisting of the following: 1. suicide ideators are individuals who admit to having thoughts of contemplating suicide, in particular, thoughts of wanting to end one's life. The suicide ideator has not yet implemented any plan of suicide. 2. Suicide attempters are individuals who have participated in nonfatal self-injurious behaviors. 3. Completed suicides are people who have engaged in fatal self-injurious behaviors (Beck, Davis, Frederick, Perlin, Pokorny, Schulman, Seiden, & Wittlin, as cited by Beck, 1986, & Hughes & Neimeyer, 1990).

Although this classification system was useful, it tended to confuse significant differences between suicide attempters and completed suicides (Hughes & Neimeyer, 1990). In particular, Bancroft, Skrimshire, and Simkin (1976) discovered that many suicide attempters indicated that their self-injurious behavior was not intended to be fatal. Their

reports suggested that they did not "attempt suicide" at all as there was absence of intent (Hughes & Neimeyer, 1990). Kreitman, Philip, Greer, and Bagley (1969) labelled these suicide-like behaviors involving wilful self-harm without lethal intentions as parasuicides.

The relationship between these various suicidal behaviors is quite complex (Hughes & Neimeyer, 1990). It becomes even more complicated and confusing as one studies the nature of this relationship. Regarding this relationship, Stengel, Cook, and Kreeger (1958) argued that completed suicides and attempted suicides represented two different populations (as cited by Linehan, 1986). In addition, Kreitman, Philip, Greer, & Bagley (1969) agreed that completed suicides and parasuicides were separate and distinct phenomena. However, other researchers continued to argue that all suicidal behaviors can be viewed on a continuum of intensity, ranging from suicidal ideation at one end to completed suicide at the other end. These investigators viewed all suicidal behaviors as being within one single population (Linehan, 1986).

Regarding a continuum of suicidal behaviors, Shneidman (1985) explained,

> Suicide and parasuicide are not the only possible categories along a dimension of lethality. Six kinds of suicidal behaviors can be distinguished along, say, a nine point continuum of lethality.

> They are: (1) Simulated suicide, with a low lethality rating; no deaths; an individual who pretends to be dead...; (2) pseudosuicide, with a low lethality rating; no deaths; an example would be an individual who swallows a small amount of sodium bicarbonate after claiming it is arsenic powder; (3) parasuicide, with medium lethality ratings (3 to 6);..., where the intention is not to effect cessation of consciousness...; (4) equivocal suicide, with medium-high lethality ratings (6, 7, 8),...; (5) attempted suicide, with a high lethality rating (8, 9) where, in effect, the individual has committed suicide but against all odds has fortuitously survived...; (6) suicide, by any method; deaths; by definition, with a high (8 or 9) lethality rating (p. 219).

Indeed, the controversy and debate over clearer classifications and definitions of suicidal behavior as well as whether such behaviors represent a single population or multiple populations will continue. However, in this present study, the term "suicidal clients" is referring to clients who may exhibit a wide range of suicidal behaviors from suicidal ideations, to attempted suicides, to completed suicides. Usually, the therapists are referring to clients who were threatening to attempt suicide or who eventually completed suicide, that is clients who were threatening to

engage in wilful nonfatal self-harm with lethal intentions, and those who participated in completed suicides.

Sources of Stress for Psychotherapists

It is not surprising that suicide is the most frequently encountered emergency situation by mental health professionals (Schein, 1976 as cited by Bongar, 1991). Deutsch (1984) completed a study in the area of sources of stress for psychotherapists. She discovered that most therapists (61%) reported that disclosure of suicidal statements were the most stressful of all client behaviors analyzed. Such disclosures occurred in approximately 11% of all client hours, or about twice a week for an average therapist. Also, over 40% of the therapists reported moderate to high stress ratings concerning irrational beliefs that they should work at peak efficiency and competency with all clients (Deutsch, 1984).

In addition, Deutsch (1984) found that for the factors of client emotionality, responsibility for client, emotional control, and competency doubts, the therapists with less experience reported significantly higher stress ratings in comparison to the more experienced practitioners. Also, older therapists made significantly lower stress ratings on five of the factors than the younger practitioners. Deutsch (1984) explained these latter findings concerning older and more experienced therapists as reporting less stress ratings

because they have come to terms with their own limitations. These practitioners no longer feel that they are the clients' saviour and so they have discovered a workable balance between their ideals and their reality.

Regarding such stressors, Deutsch (1984) believed that graduate training programs could assist training therapists in experiencing and learning to cope with such stressors as suicidal clients. Most importantly, Deutsch (1984) questioned whether a therapist's behavior which results from stress is beneficial or detrimental to the client's growth and progress.

Frequency & Impact of Client Suicide on Psychologists

Not only do therapists have to deal frequently with a client's disclosure of suicidal ideations, but they also must deal with attempted and completed suicides. Chemtob et al. (1988b) studied the frequency and impact of client suicide by doing a national survey of psychologists in the United States. Their results indicated that 22% of the psychologists reported having had a client commit suicide while in treatment. Also, the likelihood that the psychologists who had previously lost one client to suicide could expect a subsequent suicide was 39% (Chemtob et al., 1988b).

In addition, these researchers discovered that there was a significant association between the amount of training

the psychologists had and the number of patients' suicides. For instance, the psychologists with more training had a smaller rate of client suicide. However, there was no relationship between a psychologist's years of experience and the likelihood of a patient's suicide. As well, there was no significant association between a psychologist's years of experience and the probability of a subsequent patient's suicide.

As a result of losing a patient to suicide, the psychologists commented on how the suicide had affected their personal and professional lives.

> ...Increasing their focus on cues related to suicide potential, increasing collegial consultation, increasing attention to legal-forensic matters, becoming more conservative in charting and record keeping, increasing peer consultation, having increased concerns with issues of death and dying, having intrusive thoughts of suicide, and feeling anger and guilt in response to a patient's suicide (Chemtob et al., 1988b, p. 418).

Interestingly, Chemtob et al. (1988b) did not find a relationship between the psychologists' ages or years of experience and impact of patients' suicides. Therefore, these researchers acknowledged that having a client commit suicide while in treatment is a very real occupational

hazard for psychologists, not only because of the frequency of the occurrence of completed client suicide, but also because of the impact of the client suicide on the professional and personal lives of the psychologists.

Interestingly, Chemtob et al. (1988b) discovered that 49% of the psychologists who had experienced a client suicide while in treatment reported intrusive symptoms of stress in the weeks following the suicide. These symptoms of stress were comparable to symptoms of stress which were experienced by people who had a parent die and were seeking treatment. In addition, their results should provide motivation to improve training for psychologists so that they will be better prepared in dealing with suicidal clients. Since the participants reported the importance of peer and collegial support following a patient's suicide, Chemtob et al. (1988b) suggested establishing structured support, such as peer consultation, for psychologists to utilize following a suicide.

Frequency & Impact of Suicidal Clients on Psychiatrists

Chemtob et al. (1988a) discovered that the frequency of client suicide in treatment with psychiatrists is even more frequent, as 51% of psychiatrists reported having a client commit suicide while in treatment. Also, these researchers discovered that the likelihood of the psychiatrists who had previously lost a client to suicide to expect a subsequent

suicide was 55%.

Additionally, these investigators reported that psychiatrists who had more training tended to have a lower rate of suicide. However, there was no relationship between a psychiatrist's years of experience and the probability of having a patient suicide. Indeed, client suicide had similar impact on the psychiatrists' professional and personal lives as was discussed previously regarding the impact of client suicide on the psychologists' professional and personal lives (Chemtob et al., 1988a).

The impact was evident as almost half of the psychiatrists reported stress levels in the weeks following the patient's suicide that were similar to stress levels given by people who were seeking treatment following the death of a parent (Chemtob et al., 1988a). Also, these psychiatrists reported greater use of collegial and peer consultation. In addition, unlike the psychologists (Chemtob et al., 1988b), the younger psychiatrists with less experience seemed to be more affected by a patient's suicide than did the older more experienced psychiatrists. In light of these results, this study acknowledged that having a patient commit suicide is a serious occupational hazard for psychiatrists.

Frequency & Impact of Client Suicide on Therapists in Training

Not only is client suicide prevalent in treatment with both psychologists and psychiatrists, but it is also a common occurrence with therapists in training. Kleepsies et al. (1990) studied the frequency, impact, and methods of coping with client suicide by clinical psychology master's students during their training. Their study indicated that one in six (16.7%) of the psychologists in training had experienced a client suicide.

Those students who had a client commit suicide and those students who had a client attempt suicide both reported high levels of stress on the Impact of Events Scale. Some of the reactions of the psychologists in training to losing a client to suicide were as follows: initially they (75%) felt shock, followed by guilt, denial, feelings of incompetency, anger, depression, feeling blamed, relief and fear. Also, these clients commented on increased anxiety when assessing suicidal clients, feelings of helplessness, and feeling humbled. Those who had clients attempt suicide reported a wide range of emotions, such as shock, anger, sadness, loss of self-confidence, fear, discouragement, sorrow for the patient, and relief that the patient was still alive. Those who had a client attempt suicide were less apt to feel guilty than those who lost a client to suicide (10% & 63% respectively).

In addition, students who experienced client suicide reported stress levels similar to people who were experiencing bereavement. Also, students who lost a client due to suicide experienced higher stress levels than reported by professional clinicians who had experienced a client suicide. Regarding means of coping with a client suicide, these students reported mostly turning to their supervisors for support and understanding of the suicide. In addition, they had contact with the patient's family which seemed to be helpful. As well, the psychologists in training sought support from their peers and said this was moderately beneficial. However, a couple of students were concerned about being judged negatively by their peers due to the patient's suicide.

In light of these results, Kleepsies et al. (1990) suggested that training programs need to provide immediate and supportive responses to students who have lost a client to suicide, in order to prevent any traumatization and to lessen their isolation. Also, they recommended developing a safe environment that would allow the students to honestly express their reactions and feelings regarding the client's suicide. As well, this forum could provide a positive learning experience, where the students could benefit in their work with future suicidal clients.

Impact of Suicidal Clients on Psychiatric Residents

Schnur & Levin (1985) studied the impact of completed client suicides on five psychiatric residents. These psychiatric residents reported feelings of shock, anger, guilt, sadness, and helplessness. Also, they indicated an increased fear in their subsequent dealings with suicidal clients. Their increased fear in treating suicidal clients was evident as they refused to treat suicidal clients, they developed an increased reliance on hospitalization, and they were obsessively concerned with clinical decisions.

Their experiences with suicide changed their attitude towards staff, colleagues, and supervisors, as they became more self-reliant decision makers. However, the psychiatric residents did report that their coworkers and supervisors could be helpful in sharing the emotional burden of treating suicidal clients. In conclusion, Schnur & Levin (1985) indicated the necessity of the residents having a forum during supervision where they could express their feelings which arise from working with clients who have completed suicide.

Graduate Training Programs Addressing the Issue of Treating Suicidal Clients

Interestingly, despite the recommendations that were set forth by several researchers (Brown, 1987; Chemtob et al., 1988a, Chemtob et al., 1988b, & Kleepsies, 1990)

concerning the importance of having the graduate training programs of psychologists, psychiatrists, and therapists teach and discuss the treatment of suicidal clients, few graduate training programs are actually addressing this serious issue. This became evident as Bongar & Harmatz (1989) evaluated the present level of training in the area of suicide by surveying member departments (115) of the Council of University Directors of Clinical Psychology Programs in the United States. Their survey indicated that the directors of the clinical training programs rated the study of suicide as a relatively important component in graduate training in clinical psychology. However, despite its importance, 57% of the programs offered no formal training in the study of suicide. Regarding this, Berman & Cohen-Sandler (1983) reported that in order for psychologists to be able to deal effectively with suicidal clients, they need to enter therapy with confidence rather than fear. These researchers argued that psychologists' confidence can be improved if the training programs implemented more demanding standards of training in this area.

Importance of Studying Therapists' Experiences of Counselling Suicidal Clients

Thus far, from the previous research that has been discussed, one can conclude that both professional

psychotherapists and those in training will frequently treat suicidal clients and during the process of treatment, many clients will attempt or complete suicide. Hopefully, by understanding therapists' experiences of counselling suicidal clients, appropriate changes can be made surrounding the treatment of suicidal clients and the training of therapists and thus decrease client suicide.

The majority of the research that has been completed in the area of suicide has focused primarily on prediction and prevention (Bongar, 1991, 1992). However, in order to decrease the occurrence of client suicide, therapists' experiences of counselling these clients need to be understood so that treatment may be improved.

Quantitative Research on Therapists' Experiences of Counselling Suicidal Clients

Despite the importance of this topic, few studies (in addition to Deutsch, 1984; Chemtob et al., 1988a, 1988b, & Kleespies et al., 1990) have been completed in the area of therapists' experiences of counselling suicidal clients. Gurrister & Kane (1978) completed one of the few quantitative studies in this area, as they studied therapists' perceptions and treatment of suicidal clients. These researchers conducted structured interviews with 27 therapists from an interdisciplinary mental health centre. Through the means of an interview schedule, therapists'

views of suicidal clients, their therapeutic preferences, and their agreement or disagreement with various views on suicide were addressed.

Regarding the results, Gurrister & Kane (1978) discovered that suicidal clients evoked a wide range of feelings in 27 therapists. These results were evident as 10 therapists reported that anxiety was their predominant feeling with suicidal clients; whereas six therapists reported anger. Also, frustration, protectiveness, concern, and "mixed feelings" were identified as other feelings that were experienced by the therapists when working with suicidal clients. In addition, almost 100% of the therapists interviewed perceived suicidal clients as depressed; more than 50% of the therapists perceived suicidal clients as having dependent personalities; and almost 50% of the therapists perceived suicidal clients as manipulative. Also, Gurrister & Kane (1978) reported that those therapists who viewed suicidal clients as manipulative were significantly less apt to be concerned about the number of suicide attempts. As well, Gurrister & Kane (1978) proposed that it is extremely questionable how effective therapists can be with suicidal clients if they view these clients as manipulative.

Interestingly, the majority of therapists reported that they would always try to help the client decide against suicide; however, the growing perspective that suicide is a

reasonable alternative was also evident as 15 of the 27 practitioners believed that a suicidal patient has the right to commit suicide. In addition, those therapists who commented that working with suicidal clients impacted them greatly, reported feelings of anxiety. They were also more concerned about the number of suicide attempts made by the client. On the other hand, those practitioners who experienced lesser impact with suicidal clients reported feelings of anger and frustration. Almost all of the therapists believed in the importance of consultation as a resource when counselling suicidal clients, particularly with the loss of a suicidal client, as it provides emotional support and has educational value.

In a more recent study, Pope & Tabachnick (1993) investigated the degree to which therapists' experience certain feelings, the contexts in which such feelings occur, and how therapists rate their graduate program in addressing such feelings. The data were collected through the means of a questionnaire which was completed by 285 therapists ranging in various theoretical orientations. Some of the results were as follows: 97.2% of the therapists reported feeling afraid that clients may commit suicide; 89.8% of the therapists reported feeling angry at clients for being uncooperative; 87.4% of the therapists stated feeling angry with clients because they made too many demands; 64.9% of the therapists reported feeling angry with clients who made

suicidal threats or attempts; 53.3% of the practitioners felt so afraid about a client that it affected their eating, sleeping, or concentration; and 28.8% of therapists reported experiencing one client suicide.

Regarding clients' suicides, about 17% of the therapists reported having at least one female client who had committed suicide. In comparison, approximately 20% of the practitioners had experienced at least one male client who completed suicide. Also, the researchers discovered that male therapists had experienced more client suicides than their female counterparts. They explained that this could be due to the different type of clientele with whom the male therapists are working (Pope & Tabachnick, 1993).

In addition, a large percentage of the therapists rated their graduate programs as inadequate in addressing feelings of anger, fear, and sexual arousal with clients (Pope & Tabachnick, 1993). As was discussed in this article (Pope & Tabachnick, 1993) as well as earlier articles (Chemtob et al., 1988a, Chemtob et al., 1988b, & Kleespies, Smith, & Becker, 1990), working with suicidal clients and having clients commit suicide has a great impact on therapists' personal and professional lives. Therefore, Pope & Tabachnick (1993) suggested that addressing such feelings as anger, hate, fear, sexual arousal, and sexual attraction in graduate training programs would be a great educational experience for therapists in training. Additionally, it

would enable beginning practitioners to acknowledge, to examine, and to understand such feelings.

Qualitative Research on Therapists' Experiences of Counselling Suicidal Clients

Although limited quantitative research has been completed in the area of therapists' experiences of counselling suicidal clients, qualitative research in this area is even more sparse. The limited qualitative research which has been completed in this area has been conducted by the psychodynamic researchers on the subject of countertransference (Hendin, 1981; Modestin, 1987).

Countertransference is sometimes viewed as any "unconscious attitude or behavior on the part of the psychotherapist which is prompted by the needs of the therapist rather than by the needs of the client" (Pipes & Davenport, 1990, p.161). However, in this research study, the formal definition of countertransference will not be used, rather this term will be referring to the therapist's emotional reaction or response to the client. Therefore, the previous studies, which have been discussed, which investigated the therapists' feelings and emotions that arise when working with suicidal clients, could be viewed by the psychodynamic researchers as studies in the therapists' countertransference reactions (Gurrister & Kane, 1978; Modestin, 1987).

Some of the psychodynamic research (Hendin, 1981; Jorstad, 1987; Modestin, 1987; Schachter, 1988) has proposed that countertransference reactions are frequently evoked while treating suicidal clients, and these reactions may contribute to the clients committing suicide. Modestin (1987) reported four psychological and psychodynamic constellations which seem to facilitate the occurrence of counter-transference based therapeutic failures. These were as follows: difficulties in mastering the patient's aggressiveness, tolerating client's dependency, dealing with the client's erotic transference, and being loyal to the client. In addition, other countertransference responses which have been suggested are reactions, such as, feeling like an expert therapist, being bored with the client, being overly nice to the client, and rescuing the client (Pipes & Davenport, 1990).

Therefore, Modestin (1987) reported that it is essential for therapists to be aware of their countertransference reactions and self-monitor these reactions, so they do not have detrimental effects on the treatment of the suicidal clients.

Therapeutic Factors Related to Outcome

Although the research is limited in the area of therapists' experiences of counselling suicidal clients, there are numerous studies which have been completed which

investigated strategies used when working with suicidal clients. However, before discussing the reported effective strategies of working with suicidal clients, it would be beneficial to briefly examine the various therapeutic factors which seem to contribute to the client's outcome in therapy.

Lambert, Shapiro, and Bergin (1986) reviewed the psychotherapy outcome research. Interestingly, they reported that 15% of the outcome variance (or impact of psychotherapy) was accounted for by therapeutic techniques. Therapeutic techniques were referring to any factor which is unique to a specific therapy, such as hypnosis or biofeedback (Lambert, 1992). Also, expectancy or placebo effects contributed to 15% of the outcome variance (Lambert et al., 1986). Expectancy or placebo effects were referring to that portion of improvement which results from the client's knowledge of being in some type of treatment (Lambert, 1992). In addition, the remaining 30% and 40% of outcome variance was accounted for by common factors and extratherapeutic change respectively (Lambert et al., 1986).

Specifically, Lambert (1992) explained common factors as being those variables which are found in most therapies regardless of the therapist's theoretical perspective. Thus, common factors include such variables as empathy, warmth, acceptance, respect, genuineness, and validation (Duncan & Moynihan, 1994). Patterson (1984) reviewed the

research completed in the area of therapists' variables in relation to therapy outcome and reported findings supportive of the Lambert et al. (1986) review. Regarding this, Patterson (1984) concluded that empathy, warmth and genuineness account for a range of outcome variance from 25% - 40%.

Indeed, opinions vary in regard to the conceptualization of these common factors (Duncan & Moynihan, 1994). Recently, Grencavage and Norcross (1990) completed an analysis of the common factors research and they reported the most frequently addressed commonality was the development of the collaborative therapeutic relationship. Importantly, such therapist variables as empathy, warmth, genuineness, respect, validation, and acceptance contribute in part to a positive therapeutic relationship between the therapist and the client (Miller, Hubble, & Duncan, 1995). However, the strong therapeutic relationship will only develop when the therapist variables such as empathy, genuineness, and respect are perceived by the clients in such a way that it matches the clients' definitions of such variables. Thus, the therapist's empathic response must fit the empathic needs of the client in order to strengthen the alliance, as the therapist's efforts alone are not enough for the development of a strong relationship (Duncan & Moynihan, 1994).

Certainly, the client's perceptions and input in

therapy are important. This is evident as was stated previously, 40% of outcome variance is accounted for by extratherapeutic change (Lambert et al., 1986). Lambert (1992) explained extratherapeutic change as client factors and environmental factors (ie. clients' support systems) which aid in the client's recovery regardless of being in treatment. Concerning the importance of client's factors, Miller, Hubble, & Duncan (1995) expressed the following:

> In fact, the total matrix of who they are, their strengths and resources, the duration of their complaints, their social supports, the environments in which they live, even fortuitous events that weave in and out of their lives, matters more heavily than anything therapists might do (p. 57).

Regarding client factors, Bachelor (1991) reported that clients' perceptions produced stronger predictions of outcome in comparison to the therapists' perceptions. In addition, the clients perceived the most important factors to be as follows: therapists providing help, being warm and caring, involved with the client emotionally, and a willingness and effort to explore client's material. Therefore, according to the research which has been discussed in this section, regardless of the therapist's clinical orientation, the common factors and extratherapeutic change seem to contribute the most to

success in therapy.

Therapeutic Strategies with Suicidal Clients

Numerous studies have been completed in the areas of clinical assessment, management, and treatment of suicidal clients (Bongar, 1991, 1992). In particular, treatment studies usually investigate specific treatment models which are based on a particular approach or theory of understanding suicide. Despite the importance of these various treatment models, this section will not explore these models. However, it will attempt to examine the various therapeutic strategies which are utilized when working with suicidal clients. Although these various strategies have their origins within a certain theory of psychology or suicidology, the theories will not be explored. Shneidman (1984), one of the experts in the field of suicide, suggested various strategies when working with suicidal clients. He recommended that initially the therapist should assess the levels of the client's perturbation and lethality. Perturbation refers to how emotionally disturbed the client is, while lethality refers to how suicidal the client is. The levels of perturbation and lethality are to be assessed each session. Regarding such assessments, various scales are available which facilitate the evaluation process of both the client's emotional stress and lethality (Fujimura, Weis, & Cochran,

1985).

Shneidman (1984) believed that the overall goal of the therapist is to try to reduce the client's level of lethality by decreasing the client's level of perturbation. Therefore, the therapist tries to assist the client in reducing the emotional stress. Regarding this, Shneidman (1984) explained the following:

> A psychotherapist decreases the elevated perturbation of a highly suicidal person by doing almost everything possible to cater to the infantile idiosyncrasies, the dependency needs, the sense of pressure and futility, the feelings of hopelessness and helplessness that the individual is experiencing (pp. 324-325).

Specifically, the high levels of perturbation and lethality are usually a result of the client's constriction of thought process. Suicidal clients have constriction of thought as they believe they only have two choices, that of death or that of the unbearable emotional pain. Shneidman (1984) proposed that it is beneficial to reduce the level of perturbation by helping the client see other options and possibilities, in turn reducing the level of lethality. Other approaches to counselling suicidal clients are similar to Shneidman's perspective. For instance, the problem-oriented approach suggested the only means of reducing the suicidal danger is by decreasing the client's despair.

Lowering the client's despair is completed by assisting the client in redefining the problems or viewing the problems from a new perspectives and seeing other solutions to the problems other than suicide (Fisch, 1985). Consequently, both of the processes are to help the suicidal clients regain control of their lives (Fujimura et al., 1985).

Therefore, according to these two approaches, it is necessary for the therapist to perceive the client's level of perturbation or despair accurately. Interestingly, Eddins & Jobes (1994) investigated the similarity of client and therapist perceptions of the underlying dimensions of suicidality. They reported that there was a high level of agreement between the clinician and the client ratings of the client's psychological pain, external pressures, self-regard, and hopelessness. However, the clinicians consistently underrated the level of perturbation (emotional upsetness) of the clients. Based on their results, Eddins & Jobes (1994) suggested that if the clinicians are failing to perceive accurately the client's level of perturbation, then they are subsequently not concentrating on lowering the client's emotional stress. Thus, they are not lowering the lethality or suicidal risk of the client.

In addition, Shneidman (1984) recommended the importance of the therapist's hopefulness and of involving other support systems, such as significant others and agencies, in the process of reducing the client's

perturbation. Regarding the importance of establishing support systems, Durkheim (1951), who approached suicide with a sociological perspective, believed that the more lonely and isolated an individual is, the higher the suicide risk (as cited by Fujimura et al., 1985). Therefore, by establishing and maintaining support networks for the suicidal clients, their suicidal risk is decreased.

As part of Gurrister & Kane's (1978) study, they investigated the attitudes and preferences of 27 therapists regarding various therapeutic strategies. The researchers reported that the majority of the 27 therapists agreed that they would aid the clients in verbalizing their suicidal thoughts. As well, the majority of them would involve the client's significant others in their treatment and they would tend to be directive with the suicidal clients.

Regarding therapists' being directive in their counselling with suicidal clients, Rosenberg (1993) presented the psychoanalytic, the behavioral, and the cognitive behavioral theories of depression with their respective therapeutic principles. He reported that the common aim of these three types of therapies is to prevent the depressive person from suicidal acts. However, if the individual's depression worsens and suicidal ideations develop, then despite the differences in these three theories, all of them agree that their respective therapeutic styles must be altered. Thus, their adopted

psychotherapy with suicidal clients would involve counselling which is reassuring with directive interventions.

In addition, Farberow (1967) agreed that when therapists are working with suicidal clients, they need to be actively involved as the suicidal clients need to feel that something is being done, and that change is occurring. Also, it is important that the clinicians be directive in their counselling until the suicidal risk is over and the clients can resume self-responsibility. As well, the therapists need to involve significant others in the client's treatment process.

Other important strategies of working with suicidal clients involve the common factors which were discussed previously (Lambert, 1992; Lambert et. al., 1986). Such basic counselling skills as active listening, empathy, care, and patience are necessary when working with suicidal clients (Hipple & Cimbolic, 1979; Pretzel, 1972; Whitaker, 1986). As well, when counselling suicidal clients, it is essential to develop a trusting therapeutic relationship with them (Pretzel, 1972; Whitaker, 1986) and to develop the alliance quickly as there are lives at stake (Fujimura et al., 1985). In addition, Schachter (1988) discussed the importance of accepting the suicidal client's threats and despair as genuine and serious. Also, he suggested the necessity of the therapist being "fully present emotionally"

for the client so as to be supportive to the client. However, he doubted that an anxious or fearful clinician would be able to be stay present enough to fully give support to the client's despair and loneliness.

As was stated earlier, the limited qualitative research which has been completed in the area of therapists' experiences of counselling suicidal clients has been conducted by the psychodynamic researchers on the subject of countertransference (Hendin, 1981; Modestin, 1987). This research (Hendin, 1981; Modestin, 1987) suggested that the countertransference reactions, which are evoked when working with suicidal clients, could contribute to the client's suicide.

Therefore, an important strategy for therapists is to be aware of their countertransference or emotional reactions and self-monitor these responses, so they do not have detrimental effects on the treatment of the suicidal clients (Modestin, 1987). Greenson (1974) recommended that the best protection against countertransference reactions is not being free of them but rather to be conscious of them (as cited by Schachter, 1988) and to expect such reactions (Schachter, 1988).

In addition, the research suggested the importance of therapists' reviewing their clients' treatments with a colleague, in order to acknowledge and address any apparent counter-transference responses (Modestin, 1987; Schachter,

1988). Also, the importance of limiting the number of seriously suicidal patients to be treated at one time is recommended (Mintz, 1971, as cited by Modestin, 1987).

Conclusion

As a result of searching the literature on suicide, it became evident that the majority of the research that has been completed has been focused on prediction and prevention. Limited research has been conducted on the treatment of suicidal clients and even less research has been completed in the area of mental health professionals' experiences of working with suicidal clients.

There is a high frequency of completed suicides while in treatment (Chemtob et al., 1988a, 1988b). And as a result of working with attempted and completed suicidal clients, there is a professional and personal impact on the clinicians (Deutsch, 1984; Chemtob et al., 1988a, 1988b; Gurrister & Kane, 1978; Hendin, 1981; Modestin, 1987; Pope & Tabachnick, 1993;). Because of the frequency of completed suicides while in treatment and the impact on the clinicians when working with attempted and completed suicides, the research area of therapists' experiences of counselling suicidal clients seems to be of clinical importance. In order to understand this phenomenon more clearly, qualitative research needs to be completed. Therefore, this study will be a phenomenological exploration of therapists'

Chapter Three

Methodology

Question

The purpose of this study is to investigate therapists' experiences of counselling suicidal clients. As was stated earlier, there is both limited quantitative and qualitative research completed in this area. Although the available research indicates that therapists experience a wide range of feelings towards their suicidal clients, the research in the area of therapists' experiences of counselling suicidal clients remains sparse. In order to understand this phenomenon more clearly, a qualitative approach was chosen as its focus is on human experience and the data that it produces provides a thorough description of people's experiences of a certain phenomenon in their lives. Boyd (1993) explained qualitative research, "as involving broadly stated questions about human experiences and realities, studied through sustained contact with persons in their natural environments, and producing rich, descriptive data that help us to understand those persons' experiences" (p. 70).

Also, because little is known about therapists' experiences of counselling suicidal clients, this type of question lends itself more to qualitative research than to a quantitative approach. This is evident as the qualitative

methods enables the researcher to discover and understand what lies behind this unknown phenomenon (Strauss & Corbin, 1990). In addition, as Osborne (in press) stated, qualitative research methods are associated with a human science approach so, "The emphasis is upon discovery, description and meaning rather than the traditional natural science criteria of prediction, control, and measurement" (p. 5). Therefore, the qualitative approach seemed more appropriate for this study as it would be premature to make predictions or hypotheses about a phenomenon in which little is known.

Within the qualitative approach, a phenomenological research methodology was chosen to investigate therapists' experiences of counselling suicidal clients. Phenomenological methodology was utilized as it was believed to be the best means of exploring the meaning and essence of the therapists' experiences of working with suicidal clients by allowing the therapists to describe the phenomenon (Wertz, 1984). As Osborne (1990) explained,

> Phenomenological research is not intended to test an hypothesis. The aim is to understand a phenomenon by allowing the data to speak for themselves, and by attempting to put aside one's preconceptions as best one can. The method provides us with descriptions of experience which are then interpreted by the researcher from a particular theoretical perspective. However, if

there is a structure to the phenomenon it will transcend particular interpretations. (p. 81)

Therefore, due to its emphasis on understanding individuals' experiences of a phenomenon through description and meaning, a phenomenological methodology was utilized.

Presuppositions

The emphasis of phenomenological methodology is on attempting to approach the topic of study without any preconceived ideas about what may be discovered in the process of the investigation (Polkinghorne, 1983). This is essential so that the phenomenon can express itself (Osborne, 1990) However, no researcher can absolutely approach a study void of any preconceived notions concerning the study's topic and its outcome as the researcher cannot be completely separated from her own experiences (Colaizzi, 1978).

Therefore, the phenomenological approach requires the researcher to articulate her biases and preconceived ideas concerning the topic of study through a process of self-reflection which is known as bracketing. As a result of the bracketing process, any reader of the study's report will be able to take the researcher's perspective into consideration (Osborne, 1990). In addition, this process provides some protection against the study being contaminated by the researcher's views as it makes the investigator more aware

of his/her potential influence on the research (Polkinghorne, 1983). Thus, in the following section, I will describe and discuss my presuppositions and my foreunderstanding concerning therapists' experiences of counselling suicidal clients.

The whole field of suicide and therapists' experiences of counselling suicidal clients has become a rising interest of mine over the past two years, as I completed my course work and practicum requirements for my Master's in Educational Psychology in counselling psychology. My interest in this topic has escalated over the past two years, as I found myself for the first time in the position of counselling and assessing three suicidal clients. I have also had a family member who attempted suicide and a close relative who completed suicide. As well, I have lived in a small rural community where we have mourned the loss of a member to suicide. Finally, I have sat with a close friend for hours during her nine months of hospitalization due to suicidal ideations.

Certainly, my life has been touched by suicide and the threat of it in the past, and I have questioned the why's of suicide. However, I always felt that if my friend, family member, relative, or neighbour could receive professional counselling and assistance, their suicidal ideations would subside. Therefore, as I began work as a student clinician with three suicidal clients, I felt a tremendous

responsibility to be able to help them. As a result of my experiences with these clients, my interest in this area has risen.

When I turned to the sparse literature on the subject, I was shocked at the number of clients who complete suicide while in therapy or treatment. I was also surprised by the finding that having a client commit suicide while in treatment is a very serious occupational hazard for both psychologists and psychiatrists. Due to my growing interest in the topic, my concern for the number of clients who are committing suicide while in treatment, and my surprise at the limited amount of research in this area, I decided to pursue this investigation. Additionally, as a clinician in training, I do not bring a specific perspective of counselling or treatment to this study, but rather I approach the topic with a growing eclectic viewpoint.

Because of my limited professional experience of working with suicidal clients, I enter this study with limited foreunderstanding. However, one of my presuppositions is that counselling suicidal clients is a very different experience than counselling other types of clients due to its stressful nature. Also, I believe that therapists feel responsible to help the suicidal clients become healthy. In addition, I think that the therapeutic relationship with suicidal clients is very different than the relationship with other types of clients as they may be

more dependent. I presume that a therapist who is effective with suicidal clients must have a great deal of respect, empathy, and care for the clients.

Participants

The aim of phenomenological research is to describe the structure of the phenomenon, in contrast to quantitative research which is more interested in describing the group's characteristics (individuals who have experienced the phenomenon). Therefore, the objective of selecting participants in phenomenological research is to obtain a complete and varied range of descriptions of the experience (Polkinghorne, 1983). Thus, the only requirements that I used for selecting the participants in this study were that they had counselled suicidal clients and were capable of intelligently communicating their experiences (Colaizzi, 1978). Possible participants consisted of any therapists who were chartered psychologists with at least five years of experience counselling suicidal clients.

The participants were selected by one of two ways. First, I contacted a therapist whom I had met through my studies at graduate school, and inquired if this person would be interested in participating in the study. This participant agreed to take part, and gave two other names of potential participants who were also interested. Secondly, my thesis supervisor supplied me with other therapists'

names for potential participants from which the remaining three were selected.

Regarding the participants' characteristics, there were six participants in total, three females and three males. They ranged from 40 to 60 years of age, and their years of experience counselling clients (including suicidal clients) ranged from eight years to over 30 years. All of the therapists were chartered psychologists, with four having their Doctorate in Counselling Psychology (two females and two males) and the remaining two having Masters' Degrees in Counselling Psychology. All of these therapists state that they approach counselling suicidal clients with varying perspectives, ranging from eclectic to a feminist philosophy approach to a Eriksonian hypnosis position.

Concerning the number of participants needed for a phenomenological study, the researcher selects the number of participants which is necessary to illuminate the various aspects of the phenomenon under study (Wertz, 1984). Following the interviews with the six therapists in this present study, I believed that the data collected were sufficient to fully describe therapists' experiences of counselling suicidal clients. Thus, no other participants were required.

Procedure

I contacted each of the participants by telephone and

explained to them the nature and purpose of the study. In addition, I described to each of the participants my interest in exploring the area of therapists' experiences of counselling suicidal clients. I explained that if they were interested in participating in this study, it would involve a 60 to 90 minute interview, in which they would describe their experiences of counselling suicidal clients. After the participants agreed to take part in this study, I arranged suitable interview times for each of the participants. Finally, I asked the participants to reflect on their experiences of counselling suicidal clients prior to the interview, so that they would be able to illuminate the phenomenon more fully.

I began the interviews by spending time getting to know each of the participants and developing rapport with each of them. Good rapport and trust are essential, as without them an investigator is unlikely to capture the participants' descriptions of their experiences of counselling suicidal clients (Osborne, 1990). Regarding the importance of rapport and trust, Becker (1986) explained the following: "When the interviewee feels joined and understood by the interviewer, he\she can increasingly relax into recounting unpretentious life-experiences, rather than feeling compelled to analyze and synthesize them into impressive insights" (p. 113).

Rapport was developed with each participant, as I

explained my background and my interest in this area of research. Once again, the nature and the purpose of the study were explained to each of the participants as I reviewed the study description form (see Appendix A). Once the participants understood the purpose and format of the study, I informed the participants about the contents of the consent form (see Appendix B). It was explained that the descriptions of their experiences would be kept confidential. Also, the participants were informed that they could discontinue the study at any time if they so chose, and subsequently their descriptions of their experiences would be destroyed. After I answered any questions concerning the study and/or the consent form, each participant read and signed the consent form (see Appendix B) from which ethical release was obtained from the Department of Educational Psychology at the University of Alberta.

Although there are various strategies used to elicit descriptive data in phenomenological research (Wertz, 1984), I used interviewing as I believed it to be the best means of obtaining rich descriptions of the phenomenon being investigated (Becker, 1986). Specifically, a minimally structured interview was utilized, and it is described as follows: First, the participants were asked to describe their experiences of counselling suicidal clients. Secondly, I utilized a list of questions (see Appendix C)

which I had developed. These questions were used only as probes when the participants seemed to have nothing further to say about the phenomenon. These questions were to evoke conversation that would illuminate the phenomenon being studied (Osborne, 1990). Also, when the participants made ambiguous statements, I was responsible for clarifying such ideas (Polkinghorne, 1983).

All of the interviews were conducted at the therapists' offices except for one which occurred at the therapist's home. Each of the interviews lasted approximately 60 to 90 minutes. These interviews were tape recorded as permitted by the participants and were subsequently transcribed in their entirety to a written form. The second part of the interview involved assessing the validity of the data interpretation by means of the participants. Because of the busy schedules of the therapists, I sent a copy of the first and second ordered clusters of themes to each of the participants. In addition, I requested each of the participants to call me and respond concerning how true the interpretations of the data were to their experiences. All of the participants reported that overall the data interpretation seemed to represent their experiences, thus validating the findings.

Data Analysis

The key stage of phenomenological research is data

analysis. The objective of this process is to derive from the collection of therapists' protocols a description of the vital features of the phenomenon of therapists' experiences of counselling suicidal clients (Polkinghorne, 1983). The procedural steps that were involved in this present study were similar to those steps proposed by Colaizzi (1978) and they are as follows: 1. Each interview was tape-recorded and then transcribed into a written format. Characteristics of the participants during the interviews were noted, such as tone of voice, the speed at which they spoke, and their various emotional states (ie. laughing, sighing, etc.). 2. I read through each transcript several times in order to develop a sense of each of the participant's overall experiences of counselling suicidal clients. Attention was focused on the similar statements that each participant used, as well as common descriptors that each participant used to describe his or her experiences.

3. Next, I went through each transcript, and selected all of the key phrases or sentences that each participant used to describe his or her experiences of counselling suicidal clients. Colaizzi (1978) referred to this step as "extracting significant statements" (p. 59). Repeated sentences and phrases which illuminated the same aspect of the phenomenon were only selected once in each transcript. 4. These selected phrases and sentences were paraphrased by using psychological language (Polkinghorne, 1983) to

describe the overall meaning of each particular excerpt. This process was completed for each transcript and Colaizzi (1978) labelled this stage as "formulating meanings" (p. 59).

5. Following this paraphrasing process, a theme was developed which captured the essence of both the paraphrase and its matching excerpt (see Table 1). Therefore, this process of selecting the key statements, paraphrasing, and formulating themes was completed for each of the six therapists, and this procedure is known as a within persons analysis. 6. Then, all of the key statements, paraphrases, and formulated themes which were derived from each of the six therapists' transcripts were pooled together and grouped into more abstract themes. These themes were labelled first order clusters of therapists' experiences of counselling suicidal clients (see Table 2). Subsequently, these latter themes were clustered into even more highly abstract themes called second order clusters (see Table 3). This process of clustering each of the therapist's key statements, paraphrases, and themes into first and second order clusters is known as between persons analysis.

7. These final themes were to reflect the essence of the participants' experiences of counselling suicidal clients. However, to validate whether these themes reflected the essential structures of therapists' experiences of working with suicidal clients, I had to refer

the first and second order themes back to the original protocols. Once I discovered that these themes reflected the descriptions of the protocols, a copy of both the first and second order themes was given to each of therapists for validation. Interestingly, some of the therapists tended to have difficulty articulating their experiences. This may have been due to the complexity of the topic. Thus, some of the themes may be more descriptive versus phenomenological in nature. However, in light of this, all of the therapists reported that overall the abstract themes were reflective of their experiences.

Chapter Four

Results

Phenomenological research does not approach the topic under investigation with preconceived hypotheses. Instead, the objective of phenomenological investigation is to discover the essential characteristics of the phenomenon and then express these results through verbal descriptions (Polkinghorne, 1983, p 45). Therefore, in this chapter, the results of the therapists' descriptions of their experiences of counselling suicidal clients will be presented.

Through the process of data analysis with its stages of selecting key statements, paraphrasing, and deriving themes, first and second order thematic structures became evident. These structures emerged from the interviews as a result of the question, "Would you describe your experiences of counselling suicidal clients?". My objective was to try to discover the most common central structures that all of the therapists shared in regards to their experiences of counselling suicidal clients. However, I was also interested in the individual differences that were noted regarding the therapists' experiences of the phenomenon.

As a result of the process of data analysis, the following themes emerged as essential structures or markers of therapists' experiences of counselling suicidal clients:

1. Therapeutic Ingredients For Counselling Suicidal Clients

a. Effective strategies with suicidal clients

b. Ineffective strategies with suicidal clients

c. Differences in counselling suicidal clients

d. Therapeutic relationship

2. Feelings Engendered When Working With Suicidal Clients

a. Inner experiences of therapists

b. Responsibility of therapists

c. Uncertainty of working with suicidal clients

3. Therapists' Self-Care

a. Therapists' self-care

b. Therapists' need for peer support

4. Professional Growth

a. Learning with suicidal clients

b. Therapists' beliefs about suicide

Explanation of Themes

Therapeutic ingredients for counselling suicidal clients is referring to all of the various strategies which are utilized when working with suicidal clients. Feelings engendered when working with suicidal clients described the varying emotional reactions that the six therapists experienced when working with suicidal clients. The third structural theme, therapists' self-care, addressed the importance and necessity of self-care for the therapists when counselling suicidal clients. Professional growth is referring to the increased knowledge that the therapists

gained as a result of counselling this type of clientele.

Therapeutic Ingredients for Counselling Suicidal Clients

Therapeutic ingredients for counselling suicidal clients is one of the central themes which emerged from the data. Within this theme, the therapists reported both effective and ineffective strategies when working with suicidal clients. Also, they commented on the differences in counselling suicidal clients and the importance and development of the therapeutic relationship.

Effective Strategies with Suicidal Clients

Most of the therapists reported helping the clients see new possibilities or choices in their lives as being effective in promoting change. Regarding helping the clients see new options, one therapist explained,

> ...I hopefully move with them to a place where they can broaden their vision, broaden their outlook and look at all the choices that are available to them,...

In addition, another therapist believed that her past suicidal clients would also agree in the effectiveness of introducing new possibilities in the clients' lives. This was evident as she reported,

> ...I would hope they (past suicidal clients) would say something to the effect (concerning what was the most helpful thing that she did for them in

> counselling) that...she helped me see that there are other ways of looking at the situation, and my situation was not that, that desperate,...

Also, many of the practitioners believed in the importance of establishing support systems for the clients. One of the therapist's perspectives when counselling suicidal clients was continually focused on establishing support networks for the clients. For example, he reported,

> ...My way of working (with suicidal clients) is to help people find, discover, and make their own (support) systems,...

As well, one of the other therapists explained the importance of developing other support systems for the suicidal clients as she realized that she could not be available for them all the time. Concerning the importance of support systems, she explained,

> ...I will virtually never ask them to call me if they're feeling suicidal, because I can't guarantee I'll always be around, so I'll tell them that, and I'll be quite direct about it, uh...that there's a hospital or friends, their physician, there are always other places,...and I think that's important.

As well, respecting the clients and validating their experiences were other effective strategies that were reported by most of the therapists. This was apparent as

one of the therapists reported,

> ...So I (when counselling suicidal clients), I want to validate them and respect them and send that message because I may be the final one,...

In addition, another therapist believed that the reason one of his suicidal clients continued therapy was because his experiences were being valued. Regarding this, the therapist explained,

> In this guy's case (suicidal client), just being interested in what he was interested in like, really I think he was, if you're interested in what he found valuable or I think he found valuable, why he keeps coming back anyway, is that.

Also, other therapists commented on the significance of listening to the clients and considering seriously their threats and fears. One of the therapists described the necessity of listening and immediately addressing the suicidal client's concerns, as follows:

> If that person (suicidal client) calls up for example or calls the answering service, calls at off hours or something, I think there is a need to respond to that. You can't say call my service and I'll get back to you on Monday. It's about working with it then, helping that person move through that space. Because I think if it can be

> heard and you can kind of address it in the moment, you know, you can help people move beyond it.

One of the other therapists agreed with the necessity of considering the suicidal clients' threats seriously. This was evident as she commented,

> ...I think it's important for them (suicidal clients) to know that if they say something, they have to know that you take it seriously,...

The effectiveness of staying present with the suicidal clients was reported by several of the practitioners. For instance, one therapist explained that it was not any particular technique or strategy that aided the prevention of suicide. However, it was the fact that he just stayed with the client. For instance, he commented,

> ...Well I like to think the fact that I hung in there mattered, but it wasn't anything I did, specifically, I really doubt it. It was more that I hung in there and that she just kind of got tired. You know, and seemed to calm down through that,...But there was no technique, there was no approach, there was no perspective, there was no theory. That stuff was all out the window, it didn't matter. It was just like being with someone on the High Level Bridge and staying there. Except it was the office.

Also, many of the therapists considered the connection of the therapeutic relationship to be the most effective tool when working with suicidal clients. Regarding this, one of the therapists explained,

> ...My experience of most of these situations where people have been pulled off the bridge or the river or something like that is because somebody has made that personal contact and got through that wall that the person had around themselves, and said Hey I'm hearing you man, I understand you or uhm...I can relate to what you're saying, you make sense to me, so I think that there has to be some kind of connection,...

In addition, another therapist believed her clients would consider their therapeutic relationship to be the most useful aspect of therapy. This was evident as she explained,

> My guess is that people would say, uhm... that it (most helpful thing that she did as a therapist) was the relationship and access to the relationship...I think a feeling that, even just a feeling, even if they don't have to access you, a feeling that they can if they need to,...

As well, the therapist's hopefulness was considered by several of the practitioners to be an essential component of effective therapy with suicidal clients. For instance, one

of the therapists commented,

> And having to work really hard, because I think, I guess, for me in some ways with people that are that close (suicidal) it's almost like I have to hope for them. And I don't think they're in a space at that moment that they can generate their own possibilities.

Also, another therapist described his feelings of hopefulness for the suicidal client's situation as a type of measuring device that would indicate to himself if he should refer the client or not. He reported,

> ...I use that as a sort of a barometer, can I find a way to feel hopeful in this situation (with the suicidal client), if I can't, can I direct it (suicidal client) to someone, to a person (another therapist) who might be able to,...

<u>Ineffective Strategies with Suicidal Clients</u>

Many of the therapists reported that not respecting and not validating clients' experiences were ineffective strategies when counselling suicidal clients. Regarding this, one of the therapists explained,

> ...Don't worry be happy, that kind of trite advice (is not useful when counselling suicidal clients) about oh, you're taking this too seriously,...

In addition, one of the other therapists believed that a lot of the experiences that suicidal clients encounter in

hospitals are not beneficial due to the lack of respect the health profession has for this type of clientele. For instance, she reported,

> I think some of the experiences in, in emergency departments are not useful to people when they are suicidal you know, uhm...uh I remember one woman I was working with and she overdosed on some sleeping pills and the doctor walked in the next morning and looked at her and said, "So you had a little tiff with the hubby did ya?", and she hit him, and then there was this huge crisis that they were going to turf her out of the hospital...But that kind of stuff, that kind of offhanded, I mean you got to deal with everybody but that is stupid...

Also, some of the therapists regarded rescuing the clients or having clients depend on them as ineffective, since it may indicate that the clients are incompetent of helping themselves. This was apparent as one of the practitioners explained,

> Probably the least useful concept and strategy (when working with suicidal clients) that I see is somebody rescuing....If I'm rescuing, I really am, at least in my opinion, making a judgement that you're not capable of helping yourself and that you're incompetent.

As well, intensifying the emotions around the attempted suicide was considered not useful by one of the therapists. Concerning this, she commented,

> ...I suspect at some level too that intensifying the emotions around a suicide is not a good idea, that when people are in the black hole, blackening the hole doesn't help a whole lot,...

Another ineffective strategy with suicidal clients was reported by one of the therapists as over-identifying with the clients' negative experiences. This was apparent in his following comment:

> Because if you've ever been there (counselling suicidal clients) and you really do get lost (in clients' negative experiences), that option (suicide) makes perfect sense...And I don't think I'm going to be much use to somebody as a change agent, if I buy the option.

In addition, this same therapist believed that therapy is detrimental if the practitioner is afraid of taking risks. Concerning this, he reported,

> Not being willing to risk (when counselling clients in crisis) at all in case I make a mistake, is potentially really destructive. Because then what I really have is two lost souls sitting in the same office.

Differences in Counselling Suicidal Clients

All of the therapists commented on the differences in counselling suicidal clients in comparison to working with nonsuicidal clients. Many of the practitioners reported that they were more involved with establishing and maintaining support systems for the suicidal clients as the issue of safety increased with these clients. This was evident as one of the therapists explained the following:

> There is probably a whole bunch of things that I do differently (when counselling suicidal clients)...I'm probably a lot more vigilant, you know about outside support systems, uhm...internal support systems, what's going on inside you know, ensuring that they're hooked up to parts of their lives internally that are, that are stable, making sure that there is safety inside and out.

Also, some of the practitioners commented that the therapeutic relationship is different with suicidal clients due to the heightened anxiety and intensity that the therapists experience with this type of clientele. Concerning this, one of the therapists explained,

> ...So clearly there is a difference (in the relationship with suicidal versus nonsuicidal clients) for me, much more anxiety with suicidal than nonsuicidal for me.

In addition, this same therapist believed that the

therapeutic relationship would probably be more professional with suicidal clients as the practitioners would be less apt to invest emotionally with these clients. This was evident in his explanation,

> ...With somebody that is suicidal...(regarding establishing a relationship) I'm aware, I think in some ways of being more professional, uhm, doing and saying the right things, uh and yet emotionally...uhm holding back a little bit more, not making that, uh kind of investment that you would make with someone (who's not suicidal), that's different...

Also, many of the therapists reported that there is an increased emotional intensity when working with suicidal clients as there is more worry and concern with this high risk clientele. For instance, one of the therapists commented,

> For myself I think there are often these niggling worries about people who I view as having the potential to kill themselves. And always the worry that somehow they will act on that. So for me that's different (in comparison to working with nonsuicidal clients).

One of the other therapists explained his heightened emotional intensity as a result of working with a high risk clientele. Concerning this, he explained,

> Sure (counselling suicidal clients is different than counselling nonsuicidal clients), it's like uh playing poker where the limit is five dollars or ten dollars, or the limit is worth, the limit is a you know a hundred thousand dollars, you know, like the stakes are much higher,...

As well, some of the practitioners believed that they work more diligently with suicidal clients. One of the therapists described his experience as follows:

> However, if someone is suicidal, or I mean, they could be homicidal or something that really makes you stand up and notice. It is somewhat different because you're...I think working harder. Trying harder.

In addition, a few of the therapists commented that they need more time to personally and professionally process their work with suicidal clients. Concerning this, one of the practitioners reported,

> They're (suicidal clients) harder to separate from, you know, they're harder to put behind you.

<u>Therapeutic Relationship</u>

Most of the therapists believed that the therapeutic relationship is stronger with some suicidal clients than with others. For instance, one of the therapists explained,

> ...But there are just certain people (clients and therapists) that connect better,...

One of the other practitioners reported a stronger relationship with some clients who have been in therapy longer as the therapists have been through both the high and low times with these clients. This was apparent as he stated,

> ...There is a, I think, a clear sense of having been through the highs and lows with somebody (suicidal client), you have, you know the stronger the relationship.

Also, one of the therapists believed that a stronger therapeutic relationship existed only when trust had developed between the client and the practitioner. This perspective is reflected in her experience as she explained,

> ...(In a strong therapeutic relationship) They have to feel that you have their best interests at heart and that you're not going to hurt them, and that you're not going to let them hurt themselves.

In addition, one therapist reported that the therapeutic relationship may be stronger with progressing clients but that this may be a circular process as the strength of the relationship may be dependent on the client's progress and vice versa. For example, she stated,

> ...I think that maybe my relationship is best with clients who I feel that, that we will be getting somewhere,...But of course it's (the association between the strength of the therapeutic

> relationship and the client's progress) a circular thing because the more you get somewhere the better the relationship gets maybe, the better the relationship is the more you can get somewhere,...

All of the therapists reported that the therapeutic relationship changes throughout time with suicidal clients as with other clients, as some relationships grow deeper and may develop into ones of equality. One of the practitioners commented on how the relationship changes as she said,

> Well I think all relationships change over time. You don't sort of start in a place and, you know, stay in that place. I mean I think they change and some of them deepen and, you know, others move in a more separate kind of direction.

As well, one of the other therapists explained how sometimes the relationship changes into more of a peer relationship as the clients become healthier. Regarding this, he reported,

> It was kind of like it was important to her (suicidal client) that I saw how well she was. And not, you know, teacher I passed the test kind of thing, but really, you know, turned very much into a peer relationship.

However, some of the practitioners described their relationships as not being closer with suicidal clients. This was evident, as one of the therapists stated,

> No, I don't think that I feel closer to my

> suicidal clients, I think that would really be a mistake.

Feelings Engendered When Working with Suicidal Clients

Feelings engendered when working with suicidal clients is another core theme which surfaced during the analysis. This theme involved the varying inner experiences of the six therapists, including their feelings of responsibility and uncertainty when working with this type of clientele.

Inner Experiences of Therapists

Many of the therapists reported having increased amounts of worry and concern with suicidal clients. This was evident as one of the therapists explained,

> And those ones (suicidal clients) are pretty hard to put to bed in my head. I'm rolling around, you know, when I go home at night and trying to generate some possibilities in terms of helping somebody shift.

In addition, most of the therapists' fears were heightened when counselling suicidal clients as they were afraid that they would not be able to prevent the clients' suicides. One of the therapists commented on his general fear of working with suicidal clients. He explained the following:

> I think in a nutshell, the first word that comes to mind (regarding counselling suicidal clients)

is scary.

Also, one of the other therapists expressed her increased fears when she was not able to reach her supervising therapist regarding a consultation of a suicidal client. She reported,

> I tried to get a hold of him (supervising therapist concerning the suicidal client) all night and I didn't even have his home number either, I thought I did but I had his office number, that was like a backup office number, and I was just panic stricken, I was just...panicked, I didn't know what to do.

Another practitioner described his fear of over-identifying with the suicidal clients' negative experiences. Regarding this, he stated,

> I guess for me, even, you know, 15 years later, it's (counselling suicidal clients) still frightening when somebody is in that space. And trying to keep balanced, not to get lost in it myself, is probably the most frightening part of it.

As well, several of the therapists experienced feelings of frustration when counselling suicidal clients. For instance one of the therapists reported,

> This was a young lady (suicidal client) who I think from day one, really wanted to live and

> couldn't find a way to do that. And I was going reasonably nuts trying to find a way to help her to do that.

Some practitioners also experienced feelings of powerlessness when working with suicidal clients. This was evident as one therapist described the following,

> Her, her (acute suicidal client) just incredible hopelessness. A sense of that there's nothing that can be done and that even when she does leave the office, she will kill herself.

Several therapists reported being more emotionally impacted when working with suicidal clients due to the heightened emotional intensity of such work resulting in memorable counselling experiences for the therapists. Concerning this, one of the practitioners commented,

> It (memories of counselling suicidal clients) stands out for several reasons...The length of time (five hours), the energy which goes along with the length, but not just the length because of the nature of the problem. The seeming impossibility of the situation. The frustration, the lack of certainty as to what the hell do I do.

In addition, one of the therapists believed that her memories of a past suicidal client who had committed suicide were still vivid due to the increased emotional intensity of working with such clients. She explained,

> But I can see her face very very clearly and I can remember her name. You know so in some ways I think because of the drama of what happened and how I felt (shocked and upset) about it (completed suicide), a piece of that has stayed very alive for me.

In addition, many of the practitioners reported positive feelings of satisfaction, joy, and pleasure with suicidal clients who were progressing. One of the therapists described her experiences as follows:

> ...The positive part when you see that people are you know in crisis less and less and they're handling things, you know, in a different kind of way. It's a very positive thing...Celebration for the client and I mean a sense of myself kind of felling very good about that and wanting to kind of celebrate it...

Another therapist explained her positive experiences of counselling suicidal clients. She stated,

> I mean the joy of being a therapist is that you get to see those things (depression and suicidal ideations) go away for people, you get to see amazing acts of creativity on their part...

Also, some of the practitioners reported feeling humbled when working with suicidal clients as they recognized their limitations as therapists. Regarding this,

one of the practitioners commented,

> ...I think it (working with suicidal clients) makes you humble, you know, realize that uh...we have a part to play, we can have a healthy part to play, but we certainly don't have the whole part... And that we influence each other but we really don't control them (suicidal clients),...

In addition, one of the therapists reported that the clients' hopelessness activates his hopefulness and helpfulness. This was evident as he explained the following:

> ...I think there's anxiety (when counselling suicidal clients) but in a strange way their hopelessness activates my hopefulness, or I have to take this hopelessness and find ways to activate my helpfulness,...

Responsibility of Therapists

Many of the practitioners reported increased feelings of responsibility with suicidal clients. One of the therapists commented on this by saying,

> ...How I want to conduct myself (when counselling suicidal clients) as being able to say well I uh...I behaved as good as, as I could under the circumstances, yet at the same time, probably in an existential sense, being aware, very aware of that awful sense of responsibility, and uh...I

> think the natural kind of dread that one experiences when one encounters death.

Because of feelings of responsibility with suicidal clients, one therapist reported working more diligently with this type of clientele. This was evident as he explained,

> ...I may work harder to generate options and take a little more responsibility for that (with suicidal clients) than I would with another client in another area and that would be a difference,...

Also, this heightened feeling of responsibility created personal dissonance for some of the therapists as they were torn between feeling responsible for preventing the clients' suicides and wanting to pursue their own personal plans. Regarding this, one of the practitioners described the following:

> And, of course, it was late in the day, and so you're torn between obviously trying to help the person (suicidal client) and wanting her to leave....Being quite honestly, but not really being able to let her leave because she was, you know, conditioned to do so (commit suicide).

In addition, one of the other therapists reported an on-going sense of concern for past suicidal clients who previously terminated therapy. For instance, she explained,

> But I often...talking about...sort of, not a big worry, but a little worry that...and when he (past

> suicidal client) came back what happened when he found out I wasn't there (at the work place) any more. And there wasn't any way that I could tell him that.

Also, this same therapist described increased feelings of responsibility as a result of losing a client to suicide early in her counselling career. This was evident as she stated the following:

> But I remember the whole, you know, feeling of, you know, like if I only had been home, you know, when she called. If only, and then I would run through the whole...things of what I could have done and what could I have done,...

This same practitioner reported that with increased experiences of counselling suicidal clients she feels less responsible for them. Regarding this she commented,

> ...When I was beginning (counselling suicidal clients) or not so experienced of, you know, holding myself much more accountable and responsible for a client's process than I do now...

However, one of the other therapists described having constant feelings of responsibility with suicidal clients despite having increased experiences of counselling this type of clientele. His perspective was evident in the following:

> ...I don't think that (feelings of fear and responsibility) ever entirely goes away (when counselling suicidal clients) even though, you go through the experience and you, you begin to build up a sense of gee I can get through this,...

Uncertainty of Working with Suicidal Clients

Many of the therapists reported feelings of uncertainty when working with suicidal clients as they were unsure of what to do. Feelings of uncertainty were evident as one of the therapists explained his experiences.

> How hopeless she (suicidal client) was and how hard it was to know what to do because she was just here (office) and wouldn't go anywhere else.

These feelings of uncertainty seemed to result in several of the practitioners being extremely cautious with the suicidal clients. This was apparent as the previous therapist described the following:

> So...you know, when anyone is in a crisis suicidal or otherwise, it's, you know, you're always walking on eggshells and never sure exactly what to do. I think obviously you're supposed to err on the side of more caution. But sometimes it's not even clear what that is.

Another therapist compared his feelings of uncertainty and caution when working with suicidal clients to walking through a mine field. Concerning this, he reported,

> ...I picture it like threading your way through a mine field that a misstep can cause a problem. You may not be sure what your doing right all the time, but you don't want to make a misstep...

Other therapists' feelings of uncertainty resulted in the practitioners experiencing confusion and uneasiness regarding what therapeutic actions they should take with the suicidal clients. For example, one of the therapists reported,

> I (early in counselling career) had only seen her maybe four or five times and...she came in and she was acting quite strangely and I couldn't, I couldn't really determine what, what was going on for her at the time, and I started to get this really, really weird feeling that she was telling me and not telling me at the same time, it was very double-edged that she was going to make a suicide attempt.

In addition, these feelings of uncertainty seemed to create self-doubts for several therapists which resulted in these practitioners rationalizing the decisions that they had made with past suicidal clients. One of the therapists exemplified this process in the following description:

> Like I say, in retrospect, it (allowing acute suicidal client to leave the session) probably was the wrong thing to do. I mean everything turned

> out okay...But even though she had seemed quite calmed down by the end (after five hours), I don't know. Given how bad she was when she came in (sighed). Probably should have taken her myself somewhere (hospital). Of course I don't know if she would have allowed me to, see there's that problem again.

Also, the self-doubts of one of the therapists created feelings of sadness, helplessness, and frustration. These feelings were evident as she explained,

> ...Certainly, a certain frustration that, I think a lot of frustration and uncertainty about, uh what...uh am I reading this, am I reading this (suicidal client) right, am I reading it wrongly...I guess in her case (suicidal client with on-going psychiatric history) I felt, I felt very sad and helpless with regard to this woman because I'm not sure that there's a great deal I could do for her...

In addition, several of the therapists believed that these feelings of uncertainty when counselling suicidal clients results in spontaneous and instinctual therapy, doing whatever may be effective. Regarding this, one of the practitioners explained,

> It's (counselling suicidal clients) mostly seat of the pants work, I've never had a nice pretty

> canned way of working with suicidal people...It really is seat of the pants, it's like whatever will work.

Therapists' Self-Care

The third structural theme which developed is therapists' self-care. Within this theme, the practitioners explained the importance of self-care and they described the means through which they practice self-care. In particular, their need for support from their peers and colleagues are addressed.

Therapists' Self-Care

Most of the therapists engaged in self-care by realizing and accepting their limitations as practitioners as some clients will ultimately choose suicide despite therapists' talents and efforts. This was evident as one of the therapists commented,

> In part though I'm also aware that there are people (suicidal clients) in this world that it really doesn't matter how good you (therapist) are or what you do, that it's their decision and it may be the best one for them.

This perspective was also echoed by one of the other practitioners, as she explained,

> But in the final estimate if that person is going to decide to make that choice (to commit suicide),

there isn't a great deal I can do to prevent that.

In addition, many of the therapists practised self-care by not over-identifying with the clients' negative experiences. One practitioner explained his technique of not over-identifying with the clients' experiences as follows:

> I think probably more than anything else, when I worked with this girl (suicidal client) or when I work with these kind of people (suicidal), and always it's just really trying to stay grounded myself so that I don't get lost in their stuff.

Also, another therapist described his efforts of trying not to over-identify with the clients' negative experiences.

> ...So I think I try to allow myself to feel their feelings (suicidal clients) yet also...I think the place that I try to return to, uh is one of hopefulness, one of uh...faith, you might say sometimes, but belief that this problem was created some how or other therefore this means it can be solved some how or other,...

Establishing and maintaining clear roles as practitioners was another way in which many of the therapists engaged in self-care. Regarding this, one of the therapists explained,

> ...I think it's a warm and accepting relationship, but I keep a very clear delineation that I'm the

therapist,... but I'm not your friend,...

In addition, another therapist commented on the importance of maintaining a clear role as a therapist. This was apparent as she commented,

> ...I don't take home calls and I don't take calls at night you know...I make everybody aware of my boundaries around that kind of thing...I don't want to be the only person keeping this person alive cause, you know, I may be part of it but I don't want to be the only one doing it...

As well, one of the therapists explained that he maintains his self-care due to his increased appreciation for his own life and choices as a result of working with suicidal clients. Regarding this, he reported,

> I think that working with people that are close to losing their lives has really caused me personally and professionally to look at what I do with my own and how I take care of myself.

Also, one of the other therapists commented that he maintains his own self-care by having a heightened awareness of the need to process his own feelings regarding clients in crisis. Concerning this, he stated the following:

> Yeah, not helpful, not paying attention to how you feel about working with such a (suicidal) client. Again, I think it's a natural normal tendency to want to run. And that's okay, as long as you're

> aware of it and you can do something about it. If necessary refer or something. But if you're not, well then the counter-transference stuff comes in, doesn't it. Then, you don't help them at all.

Therapists' Needs for Peer Support

Many of the therapists believed in the importance of having peer support when working with suicidal clients. This was evident as one of the practitioners reported,

> ...Peer support is probably the primary thing (regarding what is useful when working with suicidal clients)...as long as I have others support.

According to most of these therapists, their colleagues provide an objective opinion and assist in confirming or disconfirming the suicidal clients' treatment plans. Regarding this, one of the practitioners explained,

> Well I think I need to. It's (consultation with colleagues concerning suicidal clients) a kind of a way of erring, you know, on the side of caution...And affirm what I'm thinking...But that's better than not asking them and not getting that affirmation and wondering...So it helps that way. And of course, on occasion, I guess you can find out something you didn't take into account and that's certainly worth knowing, especially with these kinds of people.

In addition, many of the therapists viewed peer support as essential as it enabled the practitioners to personally process their feelings and confront their issues regarding the suicidal clients. One of the therapists commented on the importance of peer support as follows:

> Ideally it should be...you should have colleagues around, you should have a supervision group, something, where you're dealing with the issues that emerge for yourself in therapy, as a therapist. Not for therapy necessarily, but for support and dialogue. You know sometimes hearing the sort of view of somebody external to a situation, where you're the one who is working in it is a very useful thing.

Professional Growth

The fourth and final central theme which arose during the study is professional growth. Within this theme, the therapists commented on their increased learning and the development of their beliefs that occurred as a result of working with suicidal clients.

Learning with Suicidal Clients

Many of the practitioners reported that working with suicidal clients increased both their learning and knowledge. One of the therapists explained that gaining

knowledge from working with suicidal clients would benefit her future clients.

> ...So to feel that people (suicidal clients) that feel that kind of desperation, I think I've learned something, continually learned something from it (counselling suicidal clients), in terms of, for the next time, or the next person because I get different insights into the person,...

Another therapist believed that the most important knowledge that she gained from working with suicidal clients was to trust her own instincts and to act upon them with this type of clientele. For instance, she explained,

> ...But the thing, the thing I learned out of that whole experience with her (client who was behaving suicidal)...uhm...was...to trust my own instinct, when I believed something was going to happen that I was probably right, you know, that my instinct was right on that and to act on that.

In addition, one of the practitioners viewed therapy as an educational process where both the clients and the therapists benefit from reciprocal learning. This was evident as he commented,

> And I learned a lot about that through him. In part I was, you know, yeah, I'd probably say using him to educate me about that dynamic, you know.

> Because I really couldn't quite understand that. So he really helped me that way. You know, I asked him if it was okay to explain why and all this stuff. And he was really into it and seemed to find that helpful.

This same therapist reported that working with suicidal clients was a paradox of learning as one learns more with suicidal clients but suffers more as well. Regarding this, he described his experience,

> ...If it's a build-up relationship, you will have learned more from it (counselling suicidal clients). And I suppose grown in that respect so...it's the old what, growth through crisis, no pain, no gain. You don't learn by doing the same think or the same easy thing.

<u>Therapists' Beliefs About Suicide</u>

The therapists seemed to have various beliefs and viewpoints concerning their work with suicidal clients. Suicide was viewed by one practitioner as a desperate act of self-definition. This was evident as he explained,

> ...I mean (with suicidal clients) there really is a desperate act of self-definition, really saying you know I can't be who I am in this world so I'm choosing to, to leave this world,...

Another practitioner viewed suicide as a loss of possibilities or choices. Regarding this, he commented,

> Most of the folks (counselling suicidal clients) that I work with, I think really, I guess the way I look at suicide is the loss of possibilities. They've uhm...they've just run out of choices. And any kind of solution or any strategy that they attempt is not working. It's gotten to the point where it's intolerable enough that that's (committing suicide) a valid choice.

Also, one of the other therapists believed that experiencing suicidal ideations is a common occurrence for most people. This was evident in her following explanation:

> I don't really think that is such an unusual thing, you know, to have suicidal ideation. I mean I think probably if we ask a fairly, normal population of people if they have ever contemplated suicide or thought about it, if the people were being honest, most people would say that they had.

In addition, another therapist held the viewpoint that if the suicidal clients worked out their suicidal ideations, they were usually able to live healthy lives. Concerning this, she reported,

> ...I think that some people (suicidal clients), it's something that can be worked through and uh dealt with and the person can get on with their lives and you see them down the road and...they're

doing fine, and then it's over,...

As well, one of the therapists described his belief that all suicidal clients have the resources to lead healthy lives as they just need help accessing them. This was apparent as he explained,

> You know, I really, yeah, I've got a fundamental working premise, and I use it with suicidal people, I use it with anyone else, and that is that everyone has the resources that they need. So it's more a matter of accessing or maybe sorting them or restructuring them or whatever.

Summary of Common Themes

As a result of the process of data analysis, the numerous themes which were just described and discussed emerged as essential structures or markers of the therapists' experiences of counselling suicidal clients. The most common themes which arose as a result of the interviews and the process of the data analysis will be briefly reviewed in this section.

The therapists reported various therapeutic ingredients or strategies for working with suicidal clients. Many of the practitioners believed that the most effective strategies to be utilized when counselling suicidal clients are as follows: 1. helping the clients see new possibilities or choices in their lives, 2. establishing support systems

for the clients, 3. therapists factors, such as being respectful and hopeful, listening and validating the clients' experiences, considering threats and fears seriously, and the importance of staying present with the clients, and 4. the importance of the therapeutic relationship. In addition, the practitioners commented on the ineffectiveness of not being respectful to the clients and not validating the clients' experiences.

As well, all of the practitioners believed that there are differences in counselling suicidal clients in comparison to counselling nonsuicidal clients. Regarding these differences, many of the therapists indicated that they are more involved with establishing and maintaining support systems with the suicidal clients as the issue of safety increases with these clients. Also, several of the practitioners commented on the therapeutic relationship being different with suicidal clients for various reasons. As well, all of the practitioners believed that the therapeutic relationship is stronger with some clients and that the relationship changes throughout time with suicidal clients as with other clients. For example, some relationships grow deeper and may develop into ones of equality.

The therapists reported both positive and negative feelings that arise when working with suicidal clients. Many of the practitioners commented on having heightened

worries and concerns with suicidal clients. Also, most of the therapists expressed increased fears when counselling suicidal clients, such as being afraid that they would not be able to prevent the suicide. In addition, several practitioners experienced feelings of frustration and many others believed that they were more emotionally impacted by their work with suicidal clients. Regarding positive feelings, many of the therapists experienced feelings of satisfaction, joy, relief, and pleasure with clients who were progressing. As well, several of the practitioners reported feeling humbled when working with suicidal clients as they recognized their limitations.

Additionally, most of the therapists commented on having increased feelings of responsibility with suicidal clients. However, several of the therapists believed that with increased experience of working with this type of clientele they feel less responsible for the suicidal clients. Uncertainty was another prevalent feeling experienced by the therapists when counselling suicidal clients as they are unsure of what to do. Many of the therapists reported that their feelings of uncertainty resulted in being cautious. As well, several practitioners commented that their uncertainty created self-doubts regarding decisions that they had made which resulted in the practitioners rationalizing these decisions.

The therapists also addressed the importance and

necessity of practicing self-care. Many of them reported engaging in self-care by realizing and accepting their limitations as practitioners, as some clients will ultimately choose suicide despite therapists' talents and efforts. Also, most of the practitioners commented on practicing self-care by not over-identifying with the clients' negative experiences. In addition, several therapists engaged in self-care by establishing and maintaining clear roles as practitioners.

As well, many of the therapists reported practicing self-care by having peer support when working with suicidal clients. Most of the practitioners commented on the importance of having peer support, as their colleagues provide an objective opinion and assist in confirming or disconfirming the suicidal client's treatment plan. In addition, several of the therapists viewed peer support as essential as it enables the practitioners to personally process their feelings and confront their issues regarding the suicidal clients.

As a result of working with suicidal clients, many of the therapists reported growing professionally as practitioners. For instance, most of the practitioners indicated that working with suicidal clients had increased their learning in the area of suicide, and they believed that their gained knowledge would benefit future suicidal clients. While working with suicidal clients, several of

the practitioners reported developing various beliefs and viewpoints concerning their work with suicide.

Regarding the common themes which emerged during the process of data analysis, each of the six therapists reviewed a copy of both the first and second order themes in order to validate the findings. Overall, the practitioners indicated that the abstract themes were representative of their experiences of counselling suicidal clients. However, despite the therapists overall agreement on the various themes which emerged during the data analysis, three of the practitioners made additional comments regarding their experiences of counselling suicidal clients.

One of these practitioners wanted to mention the importance of the use of medication with some suicidal clients who are suffering from depression and other disorders. In addition, the second therapist wanted to indicate her belief that suicide is the client's means of gaining control of his\her life. As well, the third therapist reported his belief that most therapists, when faced with a suicidal client, despite the practitioners wanting to help, have a tendency to want to run the other direction. However, despite these therapists' additional comments regarding their experiences of counselling suicidal clients, all six therapists reported that the themes which had arisen during the data analysis were truly representative of their experiences.

Chapter Five

Discussion

The present research study is a phenomenological investigation of therapists' experiences of counselling suicidal clients. In order to study the phenomenon, six therapists were interviewed concerning their experiences of working with suicidal clients. During the process of data analysis, 11 common central structures emerged which all of the therapists shared. From these 11 common themes, four overall central themes surfaced. In this section, these common themes will be discussed in relation to the current literature and implications for research and counselling will be presented.

Therapeutic Ingredients for Counselling Suicidal Clients

The therapists reported various effective strategies for working with suicidal clients. One of these useful strategies involves helping the suicidal clients see new possibilities or new choices in their lives. As was discussed previously, Shneidman (1984) believed that suicidal clients have high levels of perturbation and lethality which are usually a result of the suicidal client's constriction of thought process. He proposed reducing the level of perturbation by helping the client see other options or possibilities, in turn lowering the level

of the client's lethality.

In addition to Shneidman (1984), the problem-oriented approach also agrees with the effectiveness of aiding the suicidal clients in seeing new possibilities or choices in their lives other than suicide. This approach emphasizes the importance of reducing the suicidal client's despair or suicidal intentions by assisting the client in redefining the problems or viewing the problems from a new perspective. As well, by helping the clients see new solutions to their problems, the client's despair and suicidal ideations will decrease (Fisch, 1985).

Establishing support systems for the suicidal clients was another effective strategy that many of the practitioners reported in this present study. Most of the practitioners suggested that counselling suicidal clients is different than counselling nonsuicidal clients as therapists are more involved in establishing and maintaining support systems for the suicidal clients. Interestingly, almost all of the practitioners in Gurrister & Kane's (1978) study of therapists' perceptions and treatment of suicidal clients also believed in the importance of establishing support systems. This was evident as the majority of these therapists reported that they would involve significant others in the client's treatment plan.

As well, in an earlier study, Farberow's (1967) had stressed the effectiveness of involving significant others

in the client's treatment process. In addition, Gurrister & Kane (1978) reported that most of the therapists who had experienced a suicide in their caseload suggested that they would contact others who might be helpful to the suicidal client. Additionally, these practitioners would recommend hospitalization if they suspected the client's environment to have insufficient support.

Shneidman (1984) also agreed, as he believed another means of reducing the client's level of perturbation was by involving other support systems, such as significant others and other agencies. As well, this strategy of establishing support networks for the suicidal clients maintains Durkheim's (1951) sociological perspective. He believed that the more lonely and isolated an individual is, the higher the suicide risk (as cited by Fujimura et al., 1985). Consequently, by establishing and maintaining support systems for the suicidal clients, their suicidal risk should decrease.

In addition, several of the therapists in this present research study considered the following therapists factors to be effective when working with suicidal clients: being respectful and hopeful, listening and validating the clients' experiences, considering threats and fears seriously, and the importance of staying present with the clients. Several of these therapists factors are common factors which were discussed previously as accounting for

30% of the outcome variance (Lambert et al., 1986). Specifically, Lambert (1992) explained common factors as being those variables which are found in most therapies regardless of the therapist's theoretical perspective.

Common factors include such variables as empathy, warmth, acceptance, respect, genuineness, and validation (Duncan & Moynihan, 1994). Patterson's (1984) review of the research completed in the area of therapists' variables in relation to therapy outcome also supported the effectiveness of common factors. He concluded that empathy, warmth, and genuineness account for a range of outcome variance from 25% - 40%. Such basic counselling skills of active listening, empathy, care, and patience are even more of a necessity when working with suicidal clients (Hipple & Cimbolic, 1979; Pretzel, 1972; Whitaker, 1986).

Regarding the effectiveness of the therapist being hopeful, Shneidman (1984) suggested that this was essential in helping reduce the client's perturbation. In addition, Rosenberg (1993) agreed with the importance of being hopeful with suicidal clients. He presented the psychoanalytic, the behavioral, and the cognitive behavioral theories of depression with their respective therapeutic principles. He reported that if the depressed client becomes suicidal, all of these respective therapeutic perspectives agree that the counselling must be changed to one which is reassuring, utilizing directive interventions.

The importance of accepting the suicidal client's threats and despair as genuine and serious was echoed by Schachter (1988). Also, he agreed with the importance of staying present with the suicidal client. This was evident as he discussed the necessity of the therapist being "fully present emotionally" for the client so the client feels supported.

Another useful strategy that many of the practitioners in the current research study reported was the effectiveness of the therapeutic relationship or alliance. Many of them believed that the therapeutic relationship was the most useful tool when working with suicidal clients. As well, most of them commented that the therapeutic relationship is different with suicidal clients. It is different as there is an increased emotional intensity resulting from the increased worry and concern with this high risk clientele. As well, several of the therapists believed that the therapeutic relationship changes with suicidal clients, as well as with nonsuicidal clients, as some relationships grow stronger and may develop into ones of equality.

Pipes & Davenport (1990) agreed with the importance of a strong therapeutic relationship or alliance as they believe that it is a necessary precursor for change and progress. This is apparent as they suggested when there is no progress in psychotherapy, the therapist should first examine the therapeutic relationship. Other issues of

therapy may interact with the alliance in such a way to impede progress.

In addition, regarding the effectiveness of the therapeutic relationship, Grencavage and Norcross (1990) completed an analysis of the common factors research. They reported the most frequently addressed commonality was the development of the collaborative therapeutic relationship. Therefore, the therapeutic relationship may account for 30% of the outcome variance. Thus, the therapeutic relationship is an effective tool in therapy.

Importantly, the other common factors, or therapist's variables of empathy, warmth, genuineness, respect, validation, and acceptance contribute in part to a positive therapeutic relationship between the therapist and the client (Miller et al., 1995). Interestingly, Duncan & Moynihan (1994) reported that a strong therapeutic relationship will only develop when the therapists variables are perceived by the clients in such a way that it matches the clients' definitions of such variables. Therefore, the therapist's empathic response must fit the empathic needs of the clients in order to strengthen the alliance as the therapist's efforts alone are not enough for the development of a strong relationship.

Although a strong therapeutic alliance is important for progress with nonsuicidal clients, a trusting therapeutic relationship is essential for change with

suicidal clients (Pretzel, 1972; Whitaker, 1986). Some researchers have reported that a strong therapeutic alliance is an effective intervention with suicidal clients (Hawton & Catalan, 1987 as cited by Gibbs, 1990) as the relationship aids to prevent the suicide (Whitaker, 1986). Other research has recommended the importance of a supportive therapeutic relationship with suicidal clients as it may encourage the expression of the suicidal client's feelings and emotions (Fisch, 1985). However, this therapeutic alliance must be developed quickly when counselling suicidal clients as there are lives at stake (Fujimura et al., 1985). This may create heightened emotional intensity for the therapist and result in one of the differences between the therapeutic relationship with suicidal versus nonsuicidal clients.

Feelings Engendered When Working with Suicidal Clients

The six therapists in this present study experienced both positive and negative feelings when working with suicidal clients. Many of the practitioners commented on having heightened worries, concerns, and fears with suicidal clients, such as being afraid that they will not be able to prevent the suicide. In addition, several practitioners experienced feelings of frustration and others believed that they were more emotionally impacted by their work with suicidal clients.

Regarding therapists' feelings, Deutsch (1984) discovered that the therapists (61%) reported that disclosure of suicidal statements were the most stressful of all client behaviors analyzed. Also, Gurrister & Kane (1978) reported similar findings of therapists' feelings in comparison to those expressed by the practitioners in this present study. These researchers studied therapists' perceptions and treatment of suicidal clients. They discovered that suicidal clients evoked a wide range of feelings in 27 therapists. These results were evident as 10 therapists reported that anxiety was their predominant feeling with suicidal clients; whereas, six therapists reported anger. Also, frustration, protectiveness, concern, and "mixed feelings" were identified as other feelings that were experienced by the practitioners when working with suicidal clients.

In addition, in a more recent study, Pope & Tabachnick (1993) investigated, by means of a survey, the degree to which therapists experience certain feelings, the contexts in which such feelings occur, and how therapists rate their graduate program in addressing such feelings. Their findings are also supportive of those reported by the therapists in this present study. For instance, some of the results were as follows: 97.2% of the therapists reported feeling afraid that the clients may commit suicide; 64.9% of the practitioners stated feeling angry with clients who made

suicidal threats or attempts; and 28.8% of the therapists reported experiencing one client suicide.

These therapists also may have felt more emotionally impacted by suicidal clients as 53.3% of the practitioners felt so afraid about a client that it affected their eating, sleeping, or concentration (Pope & Tabachnick, 1993). Therefore, it is not surprising that the therapists in the present study reported an increased emotional intensity with counselling suicidal clients, as all of these research studies indicated that suicidal clients seem to create the most stress and anxiety for practitioners (Deutsch, 1984; Gurrister & Kane, 1978; Pope & Tabachnick, 1993).

In addition, most of the therapists in this present research study experienced positive feelings of satisfaction, joy, relief, and pleasure with suicidal clients who were progressing. Indeed, these are common feelings experienced by anyone who has been involved with working with suicidal clients through the process of becoming healthy. However, despite their familiarity, there does not seem to be any research completed in the area of therapists' positive feelings in working with suicidal clients.

Additionally, most of the therapists in this current study commented on having increased feelings of responsibility with suicidal clients in comparison to nonsuicidal clients. This finding is not unusual as

therapists have legal and ethical concerns when working with suicidal clients as they must do whatever they can to prevent the client from committing suicide (Fujimura et al., 1985). Therefore, it is not surprising that therapists experience heightened worry, concern, stress, and fear when working with suicidal clients (Deutsch, 1984; Gurrister & Kane, 1978; Pope & Tabachnick, 1993) as these increased anxieties are probably related to the therapists' increased feelings of responsibility with suicidal clients (Dorpat & Ripley, 1977 as cited by Berman & Cohen-Sandler, 1983). In addition, research has indicated that psychologists, psychiatrists, and practitioners in training who have lost a client to suicide experience feelings of guilt (Chemtob et al., 1988a, 1988b; Kleepsies et al., 1990; Schnur & Levin, 1985). Regarding losing a client to suicide, Bongar (1992) explained that it would be very unusual for a clinician not to experience any feelings of responsibility in a suicide death of one's client.

However, several of the therapists in this current study believed that with increased experience in working with this type of clientele they feel less responsible for the suicidal client. Regarding feeling less responsible for suicidal clients, Deutsch (1984) discovered similar findings when studying the sources of stress for psychotherapists. Interestingly, she reported that for the factors of client emotionality, responsibility for client, emotional control,

and competency doubts, the therapists with less experience reported significantly higher stress ratings in comparison to the more experienced and older practitioners.

Therefore, the more experienced and older therapists reported less stress in regards to feeling responsible for the suicidal client. Deutsch (1984) explained these latter findings concerning more experienced and older therapists reporting less stress ratings as they have come to terms with their own limitations. Indeed, these practitioners try to help the suicidal clients by preventing the suicide, but these therapists no longer feel that they are responsible for saving the whole world. They have found a workable balance between their ideals and their reality.

Therefore, these therapists try to fulfil their ethical and legal responsibilities to their clients, but they also accept the fact that at times their efforts may be futile. The six therapists in this present study also accepted their limitations as many of them reported feeling humbled when working with suicidal clients.

Uncertainty was another prevalent feeling experienced by many of the therapists in this present research study, as they reported that they are afraid that they may not know what to do concerning counselling suicidal clients. Additionally, most of these practitioners reported that their feelings of uncertainty resulted in being cautious with the clients. As well, several practitioners commented

that their feelings of uncertainty created self-doubts regarding decisions that they had made. This uncertainty resulted in the therapists rationalizing these decisions.

None of the current research has studied the area of therapists' feelings of uncertainty with suicidal clients. These feelings of uncertainty may be due to the heightened worry, concern, and fear that therapists have reported experiencing when working with suicidal clients (Deutsch, 1984; Gurrister & Kane, 1978; Pope & Tabachnick, 1993). These feelings of uncertainty may also be related to the increased feelings of responsibility that therapists experience with suicidal clients (Dorpat & Ripley, 1977 as cited by Berman & Cohen-Sandler, 1983).

Perhaps these feelings of uncertainty, caution, and self-doubt are similar to Deutsch's (1984) study, as she reported that the more experienced and older therapists scored lower stress ratings for the factor of competency doubts than the younger, less experienced therapists. Therefore, the older, more experienced therapists experienced less stress concerning their competency with suicidal clients as they may have felt more competent than the younger, less experienced practitioners.

Therapists' Self-Care

The six therapists in the current research study also addressed the importance and necessity of practicing self-

care. Many of them reported engaging in self-care by realizing and accepting their limitations as practitioners. Most of the therapists commented that they have realized that some clients will ultimately choose suicide despite their efforts and talents. Deutsch (1984) seemed to agree in the importance of therapists accepting their limitations as practitioners. This was evident as she suggested that her finding of older, more experienced therapists reporting lower stress ratings on various factors, may be due to the fact that they have accepted their limitations as therapists. Despite their efforts, they have realized that they can not save all suicidal clients.

Also, Bongar (1992) discussed how most clinicians who have lost a client to suicide and who are working with the survivors are faced with the issue of one's own mortality. In addition, these clinicians are confronted with the limits of one's own professional capacity to prevent someone from committing suicide. In addition, Brown (1987) discussed the inevitability of clinicians coming to terms with their limitations in his study on the effects of suicide on therapists in training. He reported that, "Every mental health professional must eventually develop an appropriate sense of personal limitation (both with regard to themselves and their patients), without losing therapeutic hope and without falling victim to either excessive self-doubt or self-satisfaction" (p. 109).

Also, most of the practitioners in this present study commented on practicing self-care by not over-identifying with the clients' negative experiences. In particular, the psychodynamic approach has suggested that if these emotional reactions are not monitored, then they may have detrimental effects on the treatment (Hendin, 1981; Jorstad, 1987; Modestin, 1987; Schachter, 1988). Thus, they would agree with practicing this type of self-care as it positively benefits both the therapist and client.

In addition to self-monitoring one's countertransference reactions, Greenson (1974) recommended that the best protection against such responses is not being free of them, but rather being conscious of having them (as cited by Schachter, 1988) and expect such reactions (Schachter, 1988). The research also suggested the importance of therapists reviewing their clients' treatments with a colleague so to acknowledge and address any apparent countertransference responses (Modestin, 1987; Schachter, 1988). Also, the importance of limiting the number of seriously suicidal clients to be treated at one time is recommended (Mintz, 1971, as cited by Modestin, 1987).

Several of the therapists in the current research study also reported engaging in self-care by establishing and maintaining clear roles as practitioners. Regarding the therapist's role, Pipes & Davenport (1990) explained that one perspective of therapy is that the roles that a

therapist plays will probably be different with the various clients, as the clients come to therapy with varying needs. However, Gurrister & Kane (1978) reported that more than 50% of the practitioners in their study perceived suicidal clients as having dependent personalities, and almost 50% of the therapists perceived suicidal clients as manipulative. If Gurrister & Kane's (1978) study is representative of therapists, then it is not surprising that most of the practitioners in this present study stressed the importance of establishing and maintaining clear roles as therapists.

Additionally, many therapists in this present study reported practicing self-care by having peer support when working with suicidal clients. Most of the practitioners commented on the importance of having peer support as their colleagues provide an objective opinion and they assist in confirming or disconfirming the suicidal client's treatment plan. Regarding the importance of having peer support, almost all of the therapists in Gurrister & Kane's (1978) study of therapists' perceptions and treatment of suicidal clients, viewed consultation as a necessary resource for them as therapists.

In addition, 24 of the 27 therapists reported that they would discuss a suicide death with a colleague. Sixteen of them stressed the emotional support that such a discussion would provide; whereas, eight of the therapists emphasized the educational value of such a consultation (Gurrister &

Kane, 1978). Also, psychologists and psychiatrists have reported the importance of utilizing peer and collegial support following a client's suicide (Chemtob et al., 1988a, 1988b).

As well, several of the therapists in the current study viewed peer support as essential as it enables the practitioners to personally process their feelings and confront their issues regarding the suicidal clients. This process is essential as it enables the therapist to be confronted with and to work through the emotional reactions that they have to their clients. Much research has suggested the importance of therapists reviewing their client's cases with a colleague, in order to acknowledge and address any apparent countertransference responses (Modestin, 1987; Schachter, 1988). Thus, such a process helps to prevent the therapists' countertransference reactions from negatively effecting the treatment process (Hendin, 1981; Jorstad, 1987; Modestin, 1987; Schachter, 1988).

Professional Growth

As a result of working with suicidal clients, many of the therapists reported growing professionally as practitioners. For example, most of them indicated that working with suicidal clients has increased their learning in the area of suicide. They believed that their increasing

knowledge and experience will benefit future suicidal clients. Berman & Cohen-Sandler (1983) reported that in order for psychologists, psychiatrists, and social workers to be able to deal effectively with suicidal clients, they need to enter therapy with confidence rather than fear. These researchers argued that the clinicians' confidence can be improved if training programs implemented more demanding standards of training in the area of treating suicidal clients. Consequently, a clinician will have more confidence in treating suicidal clients, if they have increased training or experience in the area. Therefore, it seems logical that future suicidal clients will benefit from the therapists in this present study having increased learning and experience in the area of counselling suicidal clients.

In addition, from working with suicidal clients, several of the practitioners reported developing various beliefs and viewpoints concerning the nature of suicide. For instance, some of the practitioners believed that suicide is the loss of possibilities or choices. This is a familiar viewpoint as it was discussed earlier in relation to Shneidman's strategies of working with suicidal clients. Shneidman (1984) believed that suicidal clients have high levels of perturbation and lethality. These high levels are usually a result of the client's constriction of thought process. Suicidal clients have constriction of thoughts as

they believe that they only have two choices, that of death or to endure the unbearable pain. Thus, suicide, according to Shneidman, is the loss of possibilities or choices.

Limitations of the Research

All research studies, despite whether they are quantitative or qualitative, have limitations. In this current research study, the first of these limitations involves the fact that the six therapists that participated in this study only represent a few of the different clinical orientations. For instance, the therapists' clinical orientations ranged from an eclectic to Ericksonian hypnosis perspective to a feminist philosophy. Although these six practitioners seem to represent varying clinical orientations, other approaches, such as psychodynamic and behavioral perspectives may have allowed other themes to emerge.

The second limitation involves the data collection and the data analysis being influenced by the researcher's biases and predispositions. It is impossible for the study and its findings not to be influenced by the researcher. However, the phenomenological approach requires the researcher to articulate her biases and preconceived ideas concerning the topic of study through a process of self-reflection which is known as bracketing. As a result of the researcher bracketing her predispositions, any reader of the

study will be able to take the researcher's perspective into consideration (Osborne, 1990).

The third limitation of the study has to do with the nature of some of the themes. Some of the therapists seemed to have difficulty articulating their experiences of counselling suicidal clients and this may be due to the complexity of the issue. Therefore, some of the themes may be more descriptive versus phenomenological in nature. However, all six therapists validated that overall the themes reflected their experiences of counselling suicidal clients.

The fourth limitation has to do with the generalizability of the findings. The six therapists that participated in this study were not a representative sample of practitioners who have worked with suicidal clients. These participants were therapists who have experienced counselling suicidal clients and were willing to participate in this study. Therefore, these findings may not be generalized to all therapists who work with suicidal clients. However, because this is a qualitative phenomenological study, it is not concerned with statistical generalizability. It is primarily interested in empathic generalizability, that is the extent to which the present study's findings resonate with the experiences of other therapists who have worked with suicidal clients (Shapiro, 1986).

Implications for Experienced Therapists & Therapists in Training

The findings from this present study suggest implications for therapists who are working with suicidal clients and for training therapists. From this present study, it is evident that the six therapists experience a wide range of feelings, such as increased worries, concerns, and fears when working with suicidal clients. Because some of these inner experiences have been reported in other studies, it seems a necessity for therapists who are working with suicidal clients to have some type of collegial support network. Encouraging collegial support should also be emphasized in graduate training programs for beginning practitioners.

Certainly, practitioners who are working in a clinic type atmosphere may already participate in such consultation groups. However, this factor becomes even more essential for those therapists who are working alone, day after day in a private practice. For therapists to effectively work with suicidal clients, they must be able to cope with their own reactions which are being evoked by such work, thus the importance of weekly consultation.

From the present findings, it is also apparent that therapists experience increased feelings of uncertainty and responsibility with suicidal clients. Consequently, it

seems essential for therapists and therapists in training who are working with suicidal clients to continually try to personally process their own reactions and feelings towards death and dying. As well, it seems a necessity for these therapists to come to terms with their responsibilities and limitations as therapists. By processing their own personal and professional reactions to the suicidal clients, they may be able to work more effectively with this type of clientele.

Finally, the present findings seem to indicate that no special techniques from any of the specific clinical orientations are more useful than others when counselling suicidal clients. However, most of the effective strategies recommended by the therapists seem to involve the basic counselling skills or common factors. For instance, many of the practitioners in this present study reported the following common factors as being effective with suicidal clients: being respectful and validating the client's experiences, being an effective listener, considering seriously the clients' threats and fears, staying present for the clients, and the effectiveness of the therapeutic relationship. Therefore, it is essential that these basic counselling skills are emphasized not only for the experienced therapist but also for the beginning therapist.

Implications for Further Research

Although this study has furthered the illumination of therapists' experiences of counselling suicidal clients, future research is necessary to confirm or disconfirm these findings. For instance, future qualitative phenomenological studies could be conducted to determine if other therapists' experiences are similar to the experiences of the six practitioners who participated in this study.

Because some of the findings (ie. the therapists' reactions or inner experiences when counselling suicidal clients) were similar to results reported by other studies, it may be beneficial to conduct a future quantitative study. Such a study could incorporate the findings from this present investigation into a questionnaire type survey. This future study could survey a large representative sample of therapists or psychologists across Canada to see if the present findings are truly indicative of all therapists.

In addition, further phenomenological research should be completed as some aspects of the therapist's experience need to be further illuminated in order to be fully understood. For instance, many of the practitioners in this present study reported feelings of uncertainty when counselling suicidal clients even though they all recommended effective strategies to utilize when working with such clients. Therefore, the nature and origins of such reactions and how such reactions impact the treatment

of the suicidal clients is still too unclear.

Indeed, it would be irresponsible to both the clients and the therapists not to complete further research in the area of therapists' experiences of counselling suicidal clients. This is evident as Gurrister & Kane (1978) explained,

> It is not only the suicidal individual who has a lot to tell us about what works in treatment, but the professionals who fail and succeed in preventive efforts. If the client does not engage in the helping relationship, we are obligated to try to study what part therapists play in what is generally deemed the patient's failure to respond to intervention (p. 13).

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Table 1

Illustration of Thematic Analysis of a Therapist's Experience

Protocol Excerpt	Paraphrase	Theme
1. I think in a nutshell, the first word that comes to my mind (regarding counselling suicidal clients) is scary, and another word that comes quickly to mind is responsibility.	Acknowledging that when he thinks of his experiences counselling suicidal clients, the two words that best describe his experiences are scary and responsibility.	Fear and responsibility; Best description of his experiences of counselling suicidal clients.
2. ...I think at those times (counselling suicidal clients) you become acutely aware, I become acutely aware of... how, what I say may have a profound effect on whether somebody lives or carries on with the desire....to not live, to die, to kill themselves.	Recognizing that when he is counselling suicidal clients, he becomes keenly aware of the significant impact that his actions may have on whether the client chooses life or death.	Awareness of the profound impact that the therapist has on suicidal client's actions.
3. ...I don't think that (feelings of fear and responsibility) ever entirely goes away (when counselling suicidal clients) even though, go through the experience and you, you begin to build up a sense of gee I can get through this.	Acknowledging that his feelings of fear and responsibility never truly go away despite developing confidence that he can get through it with every additional suicidal client.	Increased experience develops self-confidence; However the therapist's feelings of fear and responsibility are a constant.
4. ...I picture it like threading your way through a mine field that a mis-step can cause a problem. You may not be sure what your doing right all the time, but you don't want to make a mis-step.	Acknowledging that counselling suicidal clients can be compared to a soldier going through a mine field as one must be cautious as one wrong step can cause death; Recognizing that both a soldier and therapist are not sure what they are doing correctly all the time, however, they realize that they do not want to make a mistake.	Comparison of a therapist to a soldier in a mine field; Importance of being cautious (with suicidal clients) as mistakes result in death.

Table 2

First Order Clusters of Therapists' Experiences of Counselling Suicidal Clients

Thematic Clusters	Generalized Descriptions
1. Effective strategies with suicidal clients.	Five of the practitioners view helping the clients see new possibilities or choices in their lives as being effective in promoting change. In addition, five of the therapists believe in the importance of establishing support systems for the clients. As well, other effective strategies involve validating their experiences (4), showing respect (4), listening to the clients (3), considering seriously clients' threats and fears (3), and staying present with the clients (3). Also, three therapists consider the therapeutic relationship to be the most effective tool; whereas, some regard the therapist's hopefulness as an essential component (3).
2. Ineffective strategies with suicidal clients.	Five of the therapists believe that not respecting and not validating clients' experiences are ineffective strategies. Two of the therapists regard rescuing the clients or having clients depend on them as being ineffective as it may indicate that the clients are incompetent of helping themselves. Some practitioners (2) consider intensifying the emotions around the suicide or if the therapists over-identify with the clients' negative experiences as being not useful. In addition, one therapist sees it as detrimental if the therapist is afraid to take risks.

3. Therapists' self-care.	Five therapists engage in self-care by realizing and accepting their limitations as practitioners as some clients will ultimately choose suicide despite therapists' talents and efforts. Also, four therapists practise self-care by not over-identifying with the clients' negative experiences. In addition, half of the therapists engage in self-care by establishing and maintaining clear roles as practitioners (3). In addition, some of the therapists maintain their self-care due to their increased appreciation for their own lives and choices (1), and by having a heightened awareness of the need to process their feelings regarding clients (1).
4. Inner experiences of therapists.	The therapists experience both negative and positive feelings when working with suicidal clients. Five of therapists report having an increased amount of worry and concern with suicidal clients. Also, they report heightened fears when counselling suicidal clients (4), such as, not being able to prevent the suicide (3), and of over-identifying with the clients' hopelessness (1). In addition, they experience feelings of frustration (3) and powerlessness (2) when working with suicidal clients. As well, three of the therapists are more emotionally impacted when working with the suicidal clients due to the heightened emotional intensity of such work resulting in memorable counselling experiences for the therapists. However, the practitioners experience positive feelings of satisfaction, joy, and pleasure with clients who are progressing (4). Also, three of the therapists feel humbled when working with suicidal clients as they recognize their limitations, and as well, one of them report that the clients' hopelessness activates his

	hopefulness and helpfulness.
5. Responsibility of therapists.	Five of the therapists have increased feelings of responsibility with suicidal clients as one practitioner feels that he works more diligently providing support and safety for these clients. Also, this heightened feeling of responsibility creates personal dissonance for some of the therapists as they are torn between feeling responsible for the clients and wanting to pursue their own personal plans for the evening (2). One therapist reports an on-going sense of concern for past suicidal clients who terminated and a great sense of responsibility and guilt with a client's suicide. In addition, several practitioners believe that with increased experience they feel less responsible (3); whereas, the other therapists (2) report constant feelings of responsibility despite the increased experience.
6. Learning with suicidal clients.	The therapists report that working with suicidal clients increases both their learning and knowledge in the area benefiting future clients (4). One therapist believes that the most important knowledge that she has gained is that she must trust her instincts and act upon them with suicidal clients. Another therapist sees therapy as an educational process where both the client and the therapist benefit from reciprocal learning and believes that working with suicidal clients is a paradox of learning as one learns more with suicidal clients but suffers more as well.

7. Uncertainty of working with suicidal clients.	Five of the therapists report feelings of uncertainty when working with suicidal clients as they are unsure of what to do. Their uncertainty results in being cautious (3), confused (2), and\or having feelings of uneasiness (1). These feelings of uncertainty create self-doubts for three of the therapists regarding decisions that they made and this results in their rationalizing these decisions. Also, one of the practitioner's self-doubts create feelings of sadness, helplessness, and frustration. In addition, because of the uncertainty when working with suicidal clients, three of the therapists believe that it is spontaneous and instinctual work doing whatever is effective.
8. Therapists' beliefs about suicide.	The therapists have various beliefs and viewpoints concerning their work with suicidal clients. Suicide is viewed by two of the therapists as a desperate act of self-definition or a loss of possibilities or choices. Also, one therapist believes that having suicidal ideations is a common occurrence form most people. In addition, another thinks that if the suicidal clients work out their suicidal ideations, they are usually able to live healthy lives. However, one therapist reports his belief that all suicidal clients have the resources to lead healthy lives as they just need help accessing them.

9. Differences in counselling suicidal clients.	All of the therapists comment on the differences in counselling suicidal clients. Four of them report that they are more involved with establishing and maintaining support systems for the suicidal clients as the issue of safety increases with these clients. Also, four of the practitioners comment that the therapeutic relationship is different with suicidal clients for the following reasons: increased anxiety and intensity with suicidal clients (2) and relationship may be more professional as therapists are less apt to invest emotionally with these clients (1). As well, some practitioners believe that they work more diligently with suicidal clients (2) and that they need more time to personally process these types of clients (2).
10. Therapeutic relationship.	Four of the therapists comment that the therapeutic relationship is stronger with some clients, such as, those who have been in therapy longer as the therapists have been with them through both the high and low times (1) and\or a trust has developed (1). Also, one therapist reports that the relationship may be stronger with progressing clients but this may be a circular process as the strength of the relationship may be dependent on the client's progress and vice versa. In addition, all six of the therapists believe that the therapeutic relationship changes throughout time with suicidal clients as with other clients as some relationships grow deeper and may develop into ones of equality. However, two of the therapists report that their relationships are not closer with suicidal clients.

11. Therapist's need for peer support.	Four of the therapists believe in the importance of having peer support when working with suicidal clients. A colleague's support provides an objective opinion and assists in confirming or disconfirming the suicidal clients' treatment plans (4). Also, three of the practitioners view peer support as essential as it enables the therapists to personally process their feelings and confront their issues regarding the suicidal clients.

Table 3

Second Order Clusters of Therapists' Experiences of Counselling Suicidal Clients

1. Therapeutic Ingredients For Counselling Suicidal Clients

(1.) Effective strategies with suicidal clients

(2.) Ineffective strategies with suicidal clients

(3.) Differences in counselling suicidal clients

(4.) Therapeutic relationship

2. Feelings That Arise When Working With Suicidal clients

(1.) Inner experiences of therapists

(2.) Responsibility of therapists

(3.) Uncertainty of working with suicidal clients

3. Therapists' Self-Care

(1.) Therapists' self-care

(2.) Therapists' need for peer support

4. Professional Growth

(1.) Learning with suicidal clients

(2.) Therapists' beliefs about suicide

Appendix A

Study Description

I am a Masters of Education student in the Department of Educational Psychology at the University of Alberta. For my Master's thesis, I am doing a qualitative study of therapists' experiences of counselling suicidal clients. A qualitative interview method will be used in order to allow the participants to explore their personal reactions to counselling suicidal clients, as well as their professional perceptions concerning what is helpful for their clients, and what is helpful for themselves as therapists counselling suicidal clients. The results of this study will be published as my Master's thesis and as well they may be published in a professional journal.

By interviewing you, I hope to increase my awareness and understanding of therapists' experiences of counselling suicidal clients. I am very interested in exploring this area as I am presently in the counselling psychology program, and I hope to work in the counselling field. Also, I am interested in this topic as little research has been conducted on therapists' actual experiences of counselling suicidal clients.

Being a participant in this study will involve having two interviews. The first interview will allow us time to become acquainted and become aware of one another's backgrounds. After I have explained the nature and the purpose of the study, informed consent will be discussed and obtained from you. Also, during this first interview, I will ask you to describe in as much detail as possible your experiences of counselling suicidal clients. During this interview, I would like you, in your own words, to tell me of your experiences of counselling suicidal clients. This first interview will be tape recorded and will be approximately 60 minutes in length. This tape recorded interview will be transcribed into a written form using pseudonyms for your name and any other names you may mention. Only myself and my supervisor (Dr. Barb. Paulson) will have access to the original tape, and following the study, the tapes will be erased. After the tape recorded interview has been transcribed, I will analyze the data to determine the themes that represent your experiences of counselling suicidal clients.

During the second interview, I will share and discuss my understanding of your experiences with you. Also after the study is completed, I would be glad to share my findings with you. The first interview will be approximately 60 minutes in length, and the second meeting may vary depending on questions that you may have about the findings.

Once again, I would like to remind you that your participation in this study is completely voluntary and anonymous. Also, you may discontinue the study at any time without penalty. If you do decide to discontinue the study, all information about you will be destroyed. In addition, if your participation in this study raises any concerns, a referral for support and counselling will be offered. If you have any questions, please feel free to contact me at 433-8795.

Thanks Louise MacKay.

Appendix B

Consent Form

I,_____, give my permission to participate in this study. I am aware that the study is being conducted as a part of Louise MacKay's Master's thesis for her Master of Education degree, under the supervision of Dr. Barb Paulson of the Department of Educational Psychology at the University of Alberta. I am aware that the purpose of this study is to understand therapists' experiences of counselling suicidal clients. Through the use of the interview format, I will be asked to describe my experiences in as much detail as possible. I understand that I will be participating in one tape recorded interview of approximately 60 minutes in length.

I understand that my consent is voluntary and that if I choose, I can discontinue my participation in the study at any time without penalty. Also, I am aware that my name, the names of other people that I may mention, and my place of employment will be replaced with pseudonyms so that it will be impossible to recognize me as a participant in the study. In addition, I am aware that Louise and her supervisor (Dr. B. Paulson) will be the only people with access to the tape recorded interview, and I understand that she will erase the tape recording after she has transcribed the interview.

Finally, I am aware that the information obtained from the interview will be used by Louise for the purpose of her study. Also, I understand that the results of the study will be published as Louise's Master's thesis and as well the results may be published in a professional journal.

Signature:_____

Date:_____

Appendix C

List of Questions

1. Could you describe to me your actual experiences of counselling suicidal clients? Could you give me an example or two?

2. How have these experiences impacted you professionally? (Positively & negatively)

3. How have these experiences impacted you personally? (Positively & Negatively)

4. Did the nature of your relationship with the client change over time?

5. In your experience, is counselling a suicidal client different than counselling a nonsuicidal client? If so how?

6. Do you do anything differently as a therapist when counselling suicidal clients as opposed to nonsuicidal clients?

7. What did you find to be useful when counselling suicidal clients?

8. What did you find to be not useful in counselling suicidal clients?

9. Do you want to make any other comments? Is there anything else you would like to discuss concerning your experiences of counselling suicidal clients?